

**CROSSING BOUNDARIES FOR MATERNAL HEALTH:
A QUALITATIVE INVESTIGATION INTO THE ROLE
OF COMMUNITY HEALTH WORKERS AS
FRONTLINE PROVIDERS OF MATERNAL CARE IN
THE PERUVIAN ANDES**

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Abstract

Despite its status as a middle income country, Peru has one of the highest maternal mortality rates in the Americas. In the Andes region, poor, rural indigenous women are more likely to die from pregnancy related complications than their urban counterparts because they are denied the same level of maternal health services other women in the country receive. Barriers to care include geographic isolation, health staff members who do not speak indigenous languages, and cultural and ethnic discrimination. As a result, indigenous Andean women in need of maternal health services face a significant degree of social exclusion and institutionalized racism which hinders the accessibility, acceptability, and quality of maternal health services offered to them. One approach to improving access to health services has been through the use of Community Health Worker (CHW) programs. Although CHWs are recognized as an important frontline health source, there is a significant lack of literature concerning their role as community level providers of maternal health services. Using a combined grounded theory and case study methodology, this qualitative study investigates the experiences of CHWs working in Andean communities and their relationships with other community members and health and social service professionals. Findings from this study suggest that CHWs can be enabled to bring care directly to their communities in a way that community members can relate to and feel comfortable with while also forming part of the wider health system. Focusing on participants' reports of challenging cultural and ethnic boundaries through a process of ethnic bargaining and adopting professional affiliation, this study identifies CHWs as a potentially vital link between rural community members and other providers of these services. If the right factors are met, such as finding ways to navigate the tensions between traditional and biomedical health care models, CHWs can be considered critical community level health providers who can communicate the value of both models, thereby improving the accessibility, acceptability and quality of maternal health services. However, the root causes leading to social, structural and institutional boundaries to care still need to be addressed. As such, this study aims to fill a significant gap in current research on the role of CHWs in Peru, specifically in the ways they are enabled to negotiate ethnic discrimination within the health system.

Key Words: maternal health, accessibility, acceptability, quality, health services, community level approaches, community health workers, exclusion, discrimination, institutionalized racism, indigenous, ethnicity, social identity, professional identity, social mobility.

Declaration

I hereby declare that this submission is my own work and that, to the best of my knowledge, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree of the university or other institute of higher learning, except where due acknowledgement has been made in the text.

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Dedication

This thesis is dedicated to all of the women of Peru who have unnecessarily died or suffered complications as a result of pregnancy or childbirth.

Acronyms and Abbreviations

AI	Amnesty International
ACS	Community Health Agents (<i>Agentes Comunitarios de Salud</i>)
APRA	American Popular Revolutionary Alliance
CARE	Cooperative for Assistance and Relief Everywhere (Organization)
CHW	Community Health Worker
CIA	Central Intelligence Agency
CIS	Countries of the Commonwealth of Independent States
CLAS	Local Committees for Health Administration
CSDH	Commission on Social Determinants of Health
EsSalud	Social Security Institute of Peru (<i>El Seguro Social de Salud de Perú</i>)
GTM	Grounded Theory Methodology
HEW	Health Extension Worker
FEMME	Foundations to Enhance Management of Maternal Emergencies
LHW	Lady Health Worker
LHWP	Lady Health Worker Program
LMIC	Low and Middle Income Countries
MINSA	Ministry of Health Peru (<i>Ministerio de Salud del Perú</i>)
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MNCH	Maternal, Newborn and Child Health
MWH	Maternal Waiting Home
NGO	Non-Governmental Organization
PAHO	Pan American Health Organization
PARSalud	Project to Support the Reform of the Health Sector (<i>Proyecto de Apoyo para la Reforma del Sector Salud</i>)
PHC	Primary Health Care
PHR	Physicians for Human Rights
PIH	Partners in Health
PMNCH	Partnership for Maternal, Newborn and Child Health
PPC	Postpartum Care

RMNCH	Reproductive, Maternal, Newborn and Child Health
SBA	Skilled Birth Attendants
SCT	Self-Categorization Theory
SDH	Social Determinants of Health
SIA	Social Identity Approach
SIT	Social Identity Theory
SIS	Comprehensive Health Insurance (<i>Seguro Integral the Salud</i>)
SMI	Maternal and Child Health Insurance Program (<i>Seguro Materno Infantil</i>)
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VHV	Village Health Volunteer
WHO	World Health Organization

Glossary of Terms

This dissertation makes use of a number of ambiguous terms. Outlined below are the definitions of these terms as used in this study:¹

Andean: A person from the geographical region of the highlands of Peru.

Campesino: A campesino refers to a person living in a rural area. In Peru, this term is synonymous with “peasant”.

Cholo: This is a derogatory racialized term used to describe someone who is of indigenous ancestry.

Chullo: This is the name given to the traditional woolen hat worn by Andean men.

Compañero: Literally translated as “companion”, this term is used interchangeably with *campesino* usually when referring to one another.

Comunero: The Spanish word for “community member”.

Criollo: This term dates back to the Spanish colonial caste system of the 1600’s. Traditionally it was used as a label of social hierarchy to designate “purity” of Spanish blood, or Peruvians of European origin. Today in Peru, the term is more broadly used to refer to the mixed culture specific to the Peruvian Pacific Coast. However, for the purposes of this study, the term refers to Peruvians of European ancestry.

Indian: The Spanish translation for Indian can be either *indigena* or *indio*. The term *indio*, (along with *serrano*, and *cholo*) are often used interchangeably and are usually considered derogatory. *Indigena* on the other hand, refers to both highland and lowland populations of pre-conquest ancestry.

¹ Portions of this glossary were developed to be included in the author’s Masters by Research Thesis (Vidal 2010).

Indigenismo: A Latin American social movement originating in the 1920's and 1930's, in Peru it is predominantly associated with the APRA party and called for a dominant social and political role of Indian communities in Latin America.²

Indigenous: The use of this term is contestable in many ways. It is generally used to describe a person native to a particular region. In the case of Peru, the distinction is often made between highland peasants (*campesinos*) from the Andean regions, and lowland natives (*nativos*) from the Amazon rainforest. For the purposes of this study, the term is used to describe individuals of pre-conquest Andean ancestry.

Mamawasi: The Quechua name for maternal waiting homes.

Mestizo: Traditionally, mestizo refers to an individual of mixed European and indigenous ancestry. The term brings with it a number of complexities. Following de la Cadena (2000), depending on the context and the user, the term can denote emphasis on either the European ancestry or the indigenous ancestry. In the same regard, it can either imply a distance from indigenous identity or an emphasis of indigenous identity. I use the term to designate anybody of mixed indigenous and European ancestry.

Pollera: This refers to the traditional skirt worn by Andean women.

Quechua: Quechua is the language spoken by indigenous peoples of the South American Andes Mountains. I use this term interchangeably to describe both the language as well as the ethnic group. When speaking of the ethnic group, I specifically refer to those within the political boundaries of Peru.

Sendero Luminoso: The communist party of Peru, known in English as Shining Path is a Maoist guerilla insurgent organization most notable for the violence they caused during the civil war of the 80s and 90s.

² The APRA Party (American Popular Revolutionary Alliance) is Peru's oldest political party. Founded in 1924, its emphasis was based around anti-imperialist issues specific to Latin America (Central Intelligence Agency, 2010).

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Chapter 1: Introduction

1.1 The Study

This is a qualitative, grounded theory study investigating the role of Community Health Workers (CHWs) as frontline lay providers of maternal health services in rural indigenous communities of the Southern Peruvian Andes. This study was designed primarily to examine the various social and structural barriers to maternal care – specifically those driven by ethnic exclusion – and the potential influence CHWs may (or may not) have in enhancing the accessibility, acceptability and quality of formal, facility based maternal health services. By examining the barriers to care, this study thus seeks to develop a greater understanding of whether and in what ways CHWs might be enabled, or enable others to “cross boundaries” between the community and the formal health system in order to contribute to enhancing maternal health services for the indigenous population. Those who cross boundaries, or “boundary crossers”, as Kilpatrick et al. (2009, p. 284) explain, are rural health professionals who live in the communities they serve and thus “understand the culture and language of community and health service domains”. Accordingly, CHWs who act as boundary crossers “... are ideally placed to harness community capacity so as to influence community-level determinants of health” (Kilpatrick et al. 2009, p.284). A main objective of this study has therefore been to analyze the experiences and views of the individuals and groups who have experienced barriers to care, both on the user and the provider side, and who have interacted with CHWs. This includes indigenous Andean women and their families, the CHWs themselves, health professionals, government officials responsible for the development and coordination of rural maternal health improvement programs, and the various NGOs who have been working in the area to improve indigenous maternal health.

1.2 The Research Problem

Despite its status as a middle income country, many members of Peru’s population face death or life-long injuries as a result of pregnancy related complications (Bristol 2009).

Maternal mortality and morbidity rates in Peru have historically been among the highest in South America (Amnesty International 2009b; World Health Organization, UNICEF, UNFPA and The World Bank 2012). Similar to other countries, a 2013 report by Peru's Ministry of Health lists the five main causes of maternal deaths in the country as: hemorrhage, pre-eclampsia, infection, complications following abortion, and obstructed birth (Ministerio de Salud Peru 2013). Amnesty International (2009a) reported that of all the maternal deaths in the country, 27% occurred during pregnancy, 26% during childbirth and 46% during the first six weeks after giving birth. These statistics refer to the direct biological causes of maternal deaths, but they fail to highlight the more subtle indirect causes of death which disproportionately affect indigenous women and their families living in rural remote areas of the Peruvian Andes.

Indigenous Peruvians experience a number of inequalities and are largely excluded from many spheres of society (Physicians for Human Rights 2007). Encountering various forms of discrimination such as racial and ethnic discrimination when accessing health and other social services, is commonplace throughout the country and even more so in rural Andean communities where geographical, gender and language barriers may present even greater obstacles to the access and delivery of services (Bristol 2009). Further, Peru is characterized by a major social and economic gap between the richer and poorer populations of the country, with the majority of indigenous people, particularly in rural areas, living in poverty or extreme poverty (Rural Poverty Portal n.d.).³

The Quechua speaking people of the Andean region, who make up almost one-third of Peru's total population, live in the Southern Andes of Peru (Minority Rights Group International 2007). Living at the highest altitudes of any people in the Americas, Peru's indigenous Quechua speaking population are governed by the culture and traditions of their ancestors (Borthwick 2006). This is particularly evident in the beliefs and practices

³ Extreme poverty is characterized by living below the international poverty line of \$1.25 per day (Ravallion et al. 2008).

concerning pregnancy and childbirth. Such traditions, such as a preference for giving birth vertically, in their own homes and surrounded by their husbands and other relatives,⁴ are often in juxtaposition with western biomedical approaches to health, characteristic of the formal health system (Borthwick 2006). Indeed, barriers to maternal health care resulting from conflicting belief systems held between indigenous people and health professionals are one of the major indirect causes of maternal mortality in the country (Amnesty International 2009b; Borthwick 2006; Miguelez 2009).

Other indirect causes of maternal mortality can be attributed to the various social and structural barriers to care such as ethnic discrimination, language or transportation barriers, or reluctance to visit health facilities out of fear of being treated disrespectfully by the health professionals (Physicians for Human Rights 2007). Barriers such as these can often be indicative of weaknesses in the health system. For example, understaffed health facilities and poor infrastructure in rural locations can impede access to maternal health services such as routine pre-natal check-ups, emergency obstetric care should complications during childbirth arise, and postpartum care for mothers and infants (Physicians for Human Rights 2007).

In conjunction with current global trends to reduce maternal mortality, the Peruvian government has developed several plans and policies aimed to broaden the coverage of institutionalized maternity care (Physicians for Human Rights 2007). Policies such as training more health practitioners to speak local languages, implementing maternal waiting homes within or near town health centers where expectant mothers from rural areas can stay, and offering culturally adapted birthing services have been the focus of these plans (Ministerio de Salud Peru 2013). Despite these policies, systemic weaknesses in the government often result in a failure to successfully implement such measures (Lindsey n.d.).

⁴ Indigenous Quechua traditions specific to pregnancy and childbirth are introduced in Chapter 3 and discussed throughout the remainder of this thesis.

Along with government efforts, non-governmental organizations (NGOs) and health professionals have also joined attempts to improve the state of maternal health in Peru. One important approach used by all three institutions (i.e., the Peruvian government, NGOs and advocates working to improve weaknesses in the health system) was the development of community health worker (CHW) programs. The logic for introducing CHWs to improve maternal health for indigenous women facing severe barriers to care was that using local human resources could potentially enhance the utilization of facility based care. As CHWs by their definition, were expected to come from the same communities in which they provided care, they would therefore have firsthand knowledge of the specific socio-cultural health needs of the targeted population (Brown et al. 2006; Lindsey n.d.).

Despite the abundance of research concerning methods to improve global maternal health, including strategies emphasizing primary health care through the use of CHWs,⁵ the literature on CHWs in Peru has been very limited (Brown et al. 2006). The significant gap in the literature base is particularly worrisome given the potential benefits CHWs might have for improving the lives of indigenous Andean women and their families. Racial and ethnic discrimination against the indigenous population is deeply embedded in Peru's structural relations and has often been interpreted as the result of centuries of domination and subordination by the nation's ruling elite (Bristol 2009). In consequence, many of the institutions within the country have been historically dominated by the non-indigenous urban populations (Physicians for Human Rights 2007). This is evident in the way health services are carried out, such as through the preference for enforcing western based medical practices onto communities who have conflicting traditional beliefs regarding health (Lindsey n.d.). As several studies and reports have shown, CHWs may prove vital for increasing accessibility to life saving maternal health services (Brown et al. 2006; Lassi et al. 2010; Lehmann and Sanders

⁵ The following references provide a useful overview of global maternal health: (de Haan 2006; Deliver 2011; El-Khoury et al. 2011; Lori and Starke 2011; Nyamtema et al. 2011; Satti et al. 2013; UNFPA 2011b; World Bank 2014; World Health Organization, UNICEF, UNFPA and The World Bank 2012).

2007; Ofosu-Amaah 1983; Ramirez-Valles 1998; UNFPA 2011a; Walt 1990). One reason for this may be that CHWs are often the most visible of the care providers available and are thus the first point of contact for rural populations (Brown et al. 2006). CHWs can be particularly useful in regions such as the Peruvian Andes, where ethnic based discrimination is so widely accepted. This is because indigenous CHWs, by virtue of their role as frontline health providers have access to both their own communities in which they live, as well as the institutions coordinating CHW programs (i.e., government offices, NGOs and formal health facilities). This places Andean CHWs in a unique role to understand the various needs and expectations of each of these institutions, thereby potentially enabling them to act as boundary crossers to facilitate interaction between the communities and the formal health system, thus enhancing the availability, acceptability and quality of maternal health services.

1.3 Research Aims

The overall aim of this investigation has been to identify whether and in what ways CHWs might be able to facilitate interaction, or foster links between their fellow community members, facing extreme barriers to maternal health services, and the formal health system which, whether inadvertently or not, reinforces these barriers. As such, this study has aimed to identify the potential social and structural causes influencing the accessibility, acceptability and quality of rural Andean maternal health services and consequently the ways in which CHWs might be able to minimize some of these barriers. This study thus seeks to fill a very important gap in global maternal health research, with particular emphasis on understanding the role of CHWs living and working in Peru's rural Andean communities.

Given the wide social and economic gap between the indigenous and non-indigenous populations of Peru, this study seeks to understand the role of ethnic exclusion as an indirect cause of maternal mortality. As such, the focus has been to determine the ways ethnic identities are constructed and contextualized by varying members of the study population. This study was thus designed with the following aims:

- To identify the social and structural barriers to care and how these may be driven by ethnic exclusion.
- To examine the role of indigenous CHWs in order to understand their potential influence on the health seeking behaviour of Andean community members.
- To understand how the ethnic identities of the study population, in particular those of the indigenous Andean CHWs, may be utilized or negotiated as a way to facilitate interaction between community members as potential service users, and health professionals, government employees and NGO workers as providers and coordinators of care.
- To develop a substantive theory⁶ which could explain the ways CHWs might be enabled (or enable others) to cross boundaries in order to enhance the accessibility, acceptability and quality of maternal health services in Cusco's Andean communities.

1.4 Research Questions

To examine these issues and gain a comprehensive understanding of the research environment, this study poses one main research question followed by four sub-questions. The main research question is intended to define the overall objective of the study. The sub-questions are then asked in order to examine the specific issues defining the research problem and this objective. These are as follows:

Main Research Question

In what ways can the indigenous identities of CHWs be negotiated to overcome barriers to maternal health services in Cusco's rural Andean communities?

Sub-Questions

⁶ According to Charmaz (2006, p.8), a substantive theory is a theory which addresses "...delimited problems in specific substantive areas". This is explained in more detail in Chapter 4 of this thesis.

1. In what ways are maternal health services provided and utilized in the study area?
2. What is the role of CHWs in providing these services?
3. What are the main challenges as identified by participants for CHWs in enhancing the accessibility, availability and quality of maternal health services to community members?
4. To what extent has the indigenous identity of the CHWs been a factor in facilitating interaction between indigenous Andean community members and providers and coordinators of formal maternal health services in the study area?

1.5 Organization of Thesis

This thesis is divided into seven chapters. This first chapter has provided an introduction and brief background to the study and the research problem. The second chapter provides a literature review explaining the background and current debates concerning the global context of maternal health. In this chapter, maternal mortality is defined from a global perspective, and the theories concerning its predicted causes are examined. Chapter 3 provides a detailed background of maternal mortality in Peru and examines various theories concerning indigenous exclusion from the health services. Chapter 4 details the research design and methodology used to carry out this study. Chapters 5 and 6 provide a discussion of the findings and analysis using examples from the data. Accordingly, Chapter 6 presents the substantive theory constructed from the collected data. The final chapter (7) discusses how this theory can be relevant to the research questions and details the original theoretical and empirical contributions this study provides, followed by recommendations for future policymakers and other stakeholders working to improve maternal health services in the Peruvian Andes.

Chapter 2: The Social Determinants of Health and Social Exclusion in a Maternal Health Context

2.1 Introduction

This chapter introduces some of the important concepts discussed throughout this thesis. In order to understand the broader social issues contributing to maternal mortality in the Peruvian Andes, this chapter begins by explaining the Social Determinants of Health (SDH). Accordingly, a review of relevant literature pertaining to the social and economic conditions that influence the health status of different socio-economic groups is provided in conjunction with a discussion of how the SDH may influence or be influenced by social exclusion in low and middle income countries (LMICs). A discussion of maternal mortality in LMICs is then provided in order to examine some of the reasons why maternal mortality in LMICs is unequivocally high compared to higher income countries (World Health Organization 2014a).

There are multiple biological causes of maternal mortality worldwide, the majority of which result from postpartum hemorrhages, uncontrolled uterine bleeding, infections, unsafe abortion, preeclampsia or pregnancy-induced hypertension, or lack of access to emergency cesarean sections (Bristol 2009; World Health Organization 2014a). Almost all of the deaths that occur in LMICs are preventable; however this is generally complicated by a lack of access to skilled care or other necessary health services (World Health Organization 2014a). The high number of largely preventable maternal deaths is thus reflective of the extreme social inequalities existing between the rich and poor in many of these regions (Bristol 2009). This chapter therefore begins by explaining how the SDH and social exclusion might influence the availability, accessibility and quality of maternal health services before, during and after pregnancy (2.2). A review of the global context of maternal health is provided, highlighting the current theories and policy initiatives aimed to improve global maternal health (2.3). Section 2.4 discusses some of the causes of maternal mortality and current approaches to care. This is followed by an examination of the development of primary health care and the

introduction of community health worker programs into LMICs (2.5). Section 2.6 concludes this chapter.

2.2 The SDH and Social Exclusion

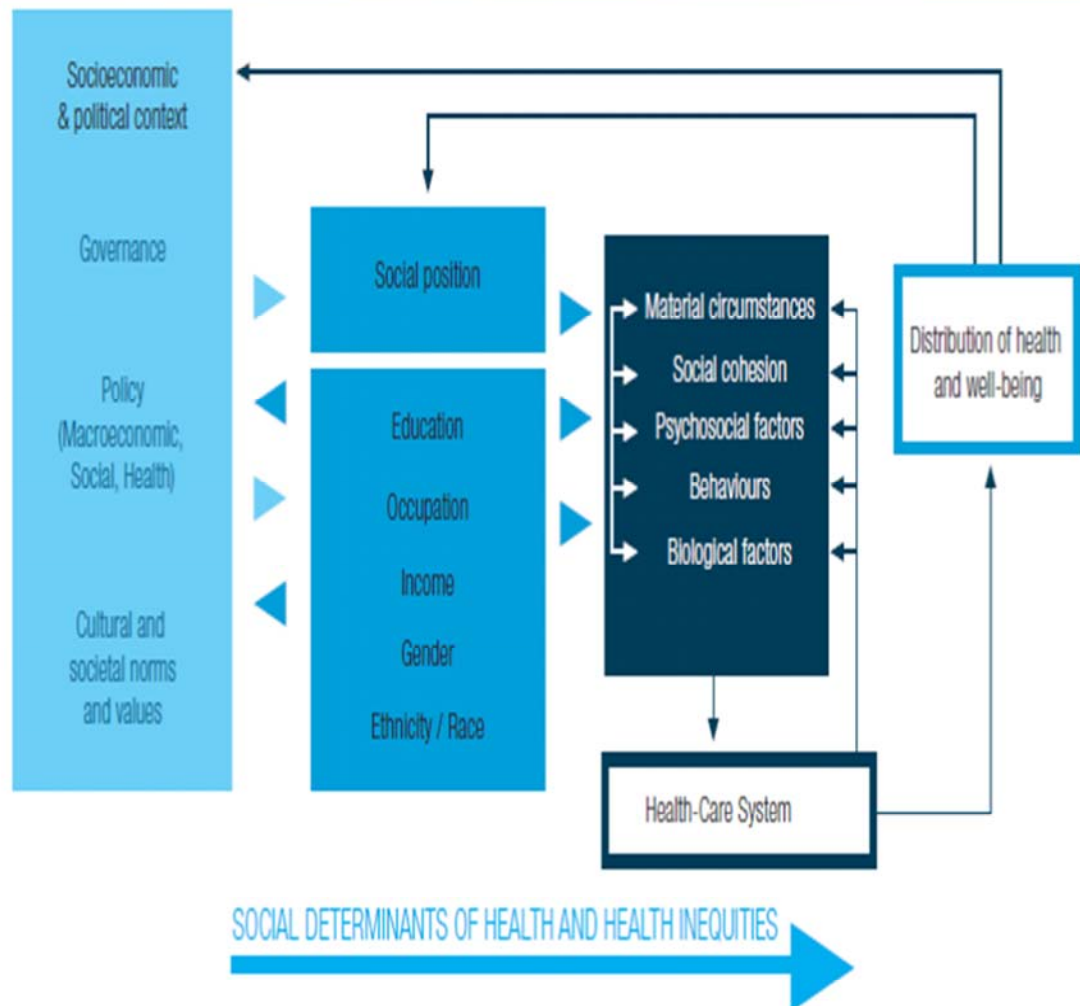
The most recent definition of the SDH as provided by the WHO (2013, para. 1) states that:

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

It is important to point out the differences between health *inequities* and health *inequalities*. Health inequities refer to the *avoidable* differences in health statuses between populations (World Health Organization 2015c). These are commonly distinguishable by differences in morbidity or mortality between people from different socio-economic classes (World Health Organization 2015a; World Health Organization 2015c). Accordingly, health inequities often arise from health *inequalities* which are sometimes determined by biological variations between people, but are also usually “...attributable to the external environment and conditions mainly outside the control of the individuals concerned” (World Health Organization 2015a, p.2). The SDH, therefore, refer to a set of social and economic conditions which influence health status and contribute to increased health inequities (World Health Organization 2006). Even more specifically, according to the introductory section of the Commission for the Social Determinants of Health (CSDH)⁷ Final Report, “the conditions in which people live and die are, in turn, shaped by political, social, and economic forces” (Commission on Social Determinants of Health 2008, p.3). Figure 1 displays a visual representation of the SDH.

⁷ The CSDH was created by the WHO in March 2005 to identify the links between health inequities and socio-economic status.

Figure 4.1 Commission on Social Determinants of Health conceptual framework.



Source: Amended from Solar & Irwin, 2007

COMMISSION ON SOCIAL DETERMINANTS OF HEALTH | FINAL REPORT

Figure 1: The social determinants of health (Commission on Social Determinants of Health 2008)

One SDH is captured by the concept of *social exclusion*, of which there are several definitions. Barnes (2005, p.15), for example, defines it as “...the multi-dimensional dynamic process of being shut out, fully or partially, from the economic, social and cultural systems that determine the social integration⁸ of a person in society.” Also referring to it as multidimensional, Levitas et al. (2007, p.25) define social exclusion as “...a complex and multidimensional process [that] involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities available to the majority of people in society, whether in economic, social, cultural or political arenas.” Yet another definition provided by Landman (2006, p.19) explains how social exclusion “...involves discrimination against individuals and groups based on one or many different social attributes or elements of social identity⁹ [and where] such discrimination can occur as the result of formal or informal activities of the state as well as institutions and organisations in the private sector...” The key point to draw from the last definition in particular is that social exclusion, as reflected through discrimination, is often deeply integrated in the institutions which make up a society. For example, discrimination against those who are excluded due to certain social attributes (e.g., varying cultural practices), which set them apart from society, are often perpetuated by those who have greater access to power, and therefore manage or oversee the structure of these institutions (Mathieson et al. 2008).

One way to describe the social arrangements that make excluded individuals and populations more susceptible to discrimination or harm is through “structural violence” (Farmer 2004). This concept, originally developed by Norwegian Sociologist Johan Galtung, refers to a form of violence that results from social structures or institutions

⁸ The working definition of social integration as defined by the United Nations Department for Economic and Social Affairs, Division for Social Policy and Development (2005) is as follows: “Social Integration can be seen as a dynamic and principled process where all members participate in dialogue to achieve and maintain peaceful social relations. Social integration does not mean coerced assimilation or forced integration”

⁹ Social identity is a key concept in this thesis and will be described in greater detail in Chapter 4 and beyond. Social identity in general however refers to the way an individual identifies him or herself in terms of group membership (Hogg and Vaughan 2008).

that cause harm to people by preventing them from meeting their basic needs (Galtung 1969). Paul Farmer, the American medical anthropologist and co-founder of Partners in Health has written extensively on structural violence in anthropology and social medicine. Accordingly, he emphasizes that “the arrangements are structural because they are embedded in the political and economic organization of our social world [and] they are violent because they cause injury to people” (Partners in Health 2011, p.1). Similarly, renowned French sociologist, Pierre Bourdieu famously explained the relationship between social inequality and violence in terms of power dynamics in society. His notion of “symbolic power” maintains that discriminatory actions are reinforced through uneven power relations where there is an unconscious recognition of a social hierarchy (Bourdieu 1977). That is, where the dominated and the dominators mutually accept their given position in society (Bourdieu 1977). Bourgois (2009, p.17), for example, explains this invisible violence as “‘misrecognized’ by both protagonists and victims – who are often one and the same [and where] this misrecognition legitimizes to the general public the policies and institutions that politically impose suffering on the socially vulnerable.”

As social exclusion has been recognized as a factor in health inequalities, it has therefore played a fundamental role in international development research and academic discourse throughout Western Europe and increasingly other parts of the world (Mathieson et al. 2008). The origins of the concept can be traced as far back as Aristotle who viewed exclusion in terms of a lack of individual choice or freedom to make decisions (Rogers et al. 2008). According to Aristotle, for example, “...an impoverished life [was] one without the freedom to undertake important activities of choice” (Rogers et al. 2008, p.245). Closely linked to poverty and deprivation, social exclusion was thus understood to influence the livelihoods of people and can be characterized by limitations in personal decision-making (Kadun and Gadkar 2014).

Despite the antiquity of concept, it wasn't until the mid 1970s that contemporary interest in social exclusion developed (Rogers et al. 2008). Coined in France by then Secretary of State for Social Action, René Lenoir, the term offered a practical way to identify “the

excluded” of the time (Sen 2000). Lenoir spoke of the following to define the portion (a tenth) of the French population that was excluded:

Mentally and physically handicapped, suicidal people, aged invalids, abused children, substance abusers, delinquents, single parents, multi-problem households, marginal, asocial persons, and other social ‘misfits’. (Sen 2000, p.1)

A description such as the above offered a way to differentiate between those who were excluded and those who were not and is reflective of the social inequalities that were occurring in France at the time. Mathieson et al. (2008, p.5) for instance, explain that high unemployment rates in France resulted in excluding people from the “salary relationship”, thus eventually leading to “...the individualization of social protection in the context of globalization and increasing labor flexibility” (Castel 1998; Castel 2004; Esping-Andersen 2000; Rosanvallon 1995). During the time of Lenoir, it was argued that French society was going through a period where the pursuit of salaried employment was the foundation for *social citizenship*, or an individual’s ability to access full social rights (Mathieson et al. 2008; McKeever 2007). According to Mathieson et al. (2008, p.5), Lenoir further defined excluded people as “...population groups that were unable to find a place in the salary nexus and whose rights to social citizenship were thus limited or, at least, not recognized”.

In addition to its relationship with salaried employment, *social citizenship* is also important because it is central to the concept of social exclusion and the health inequalities stemming from exclusionary relationships that are based on uneven power relations. The general concept of *citizenship* developed by Marshall (1963) and summarized by McKeever (2007) can be divided into three main categories: *civil*, *political* and *social*. *Civil citizenship* encompasses “the rights necessary for individual freedom – liberty of the person, freedom of speech, thought and faith, the right to own property and to conclude valid contracts” (McKeever 2007, p.425). *Political citizenship* refers to “the right to participate in an exercise of political power, as a member of a body invested with political authority or as an elector of such a body” (McKeever 2007, p.425). *Social citizenship* thus covers “the right to a modicum of social welfare and

security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society (McKeever 2007, p.425). Accordingly, social citizenship coincides with the varying degrees of access to social rights available to excluded and non-excluded groups (such as the right to a healthy pregnancy, childbirth and postpartum, as in the case of this study). Excluded people are therefore those who experience varying degrees of exclusion from the rights of citizenship and the social and economic conditions necessary to live a healthy and meaningful life.

Social exclusion thus explains how some individuals or groups are blocked from certain rights and opportunities that might be available to others. Though there is no unified definition of social exclusion as explained above, the abbreviated working definition for social exclusion as stated in the DFID Social Exclusion Review (Beall and Piron 2005, p.9) is as follows:

Social exclusion is a process and a state that prevents individuals or groups from full participation in social, economic and political life and from asserting their rights. It derives from exclusionary relationships based on power.

The problem of social exclusion is consequently usually tied to the concept of “equal opportunity”, which can be defined as “...a stipulation that all people should be given access to opportunities for advancement and treated similarly when competing for jobs, housing or other resources” (Boundless 2014). Patterns of *unequal* opportunity are thus commonly referred to as *social inequalities* (Sociology Guide 2015b). Similar to health inequalities, social inequalities can be defined as follows:

Social inequality refers to the ways in which socially-defined categories of persons (according to characteristics such as gender, age, ‘class’ and ethnicity) are differentially positioned with regard to access to a variety of social ‘goods’, such as the labour market and other sources of income, the education and healthcare systems, and forms of political representation and participation. These and other forms of social inequality are shaped by a range of structural factors, such as geographical location or citizenship status... (CEELBAS 2015)

Social inequalities thus reflect perceived differences between individuals which are often also reflected by uneven power relations. Therefore, a possible outcome in societies in which some members of a population are discriminated against, or face *unequal* opportunity, is that of exclusion and subsequently health inequities and inequalities determined by the SDH, which can also have significant ramifications for maternal health outcomes in LMICs.

2.2.1 The SDH and Maternal Health

Despite the lack of consensus in defining social exclusion, many global health policies have been developed using a social exclusion framework based on the SDH (Beall and Piron 2005). Following the World Social Summit in Copenhagen in 1995, several multilateral development agencies such as the World Bank and the International Labour Organization adopted such a framework, emphasizing attention on the causes and impact of poverty and social disadvantage (Beall and Piron 2005). The links between health inequities and socio-economic status gained renewed prominence with the March 2005 launch of The Commission of Social Determinants of Health (CSDH) created by the World Health Organization in 2006 (World Health Organization 2006). Since then, several policy recommendations have been put forth based on the assumptions of social exclusion and the SDH (Commission on the Social Determinants of Health 2008; World Health Organization 2014b). The SDH model is not without criticism however. Preda and Voigt (2015), for example, argue that the SDH is based on a number of normative assumptions over the relationship between health and inequalities in wealth and power. Accordingly, an important assumption that Preda and Voigt (2015, p.30) highlight is that “all health inequalities that result from social inequalities are unfair” and thus a matter of social justice. Nevertheless, the SDH model, though potentially based on normative assumptions over what may or may not be just as decided by those who hold greater power, is useful for highlighting the links between social and health inequalities and uneven power relations within societies.

Farmer (2004), similarly stresses that the most socially vulnerable members of a population (such as poor women in rural remote locations) are more susceptible to invisible forms of violence (i.e., structural violence) which can have a significant impact on their ability to access health services as described in the following passage:

Undoubtedly, the most substantial barriers to health care for poor women have been the high costs – including user fees charged by health facilities, the high costs of transportation, and lost work time traveling to the nearest clinic. Women are also frequently inhibited from accessing health care by social and cultural factors, including stigma, reticence to expose highly personal matters to medical attention, and intimidation by their husbands and families. (Partners in Health 2011, p.2)

Such factors inhibiting women's access to health care are also argued to be engrained within institutional structures such as the health facilities and thus have distinct ramifications for maternal health.¹⁰ For instance, one of the most telling indicators of health inequities worldwide is the state of maternal mortality (Bristol 2009). Countries with high maternal mortality figures are generally also characterized by inadequate health systems, corrupt political institutions, poverty, ethnic divisions and gender inequalities, all of which are conditions for social exclusion (Bristol 2009). Marginalized members of a population such as women or ethnic minorities are therefore often the most at risk of being excluded and experiencing poor maternal health outcomes (Beall and Piron 2005).

The SDH, social exclusion and structural violence (which by its nature is often invisible), are thus all shaped by the more visible institutions and ideologies of a society. The resulting power imbalances between those who are excluded and those who are not can have the dangerous result of widening the gap between rich and poor in low-resource settings such as LMICs. Critically examining the potential causes of the SDH and how these influence maternal health worldwide is thus a crucial step for identifying ways to improve the lives of at risk or excluded women and their families around the world.

¹⁰ Barriers such as these will be discussed in more detail in the following section of this chapter.

2.3 The Global Context of Maternal Health

Each year, over a quarter of a million women around the globe die from pregnancy related complications (World Health Organization 2014a). The majority of these largely preventable deaths occur in LMICs, and in particular in resource poor settings such as rural remote areas (Hunt and Bueno de Mesquita 2010) (See Figure 2 for a map of maternal mortality statistics by country as of 2005). The global maternal health problem was acknowledged during the Millennium Summit in 2000 where it became one of the eight Millennium Development Goals (MDGs) (World Health Organization 2014a). The fifth MDG (MDG 5) was developed with the aim to improve maternal health worldwide (World Health Organization 2014a). The two targets associated with MDG 5 are: 1) to reduce the maternal mortality ratio (MMR)¹¹ by three quarters, between 1990 and 2015 and 2) to achieve universal access to reproductive health by 2015 (UNICEF et al. 2008).

¹¹ Maternal mortality ratio is the number of maternal deaths per 100,000 live births. This is not to be confused with maternal mortality rate (MMRate), which is the number of maternal deaths divided by the number of women in a population of reproductive age (The World Bank 2014; Women and Children First UK 2015).

Maternal mortality ratio, by country, 2005

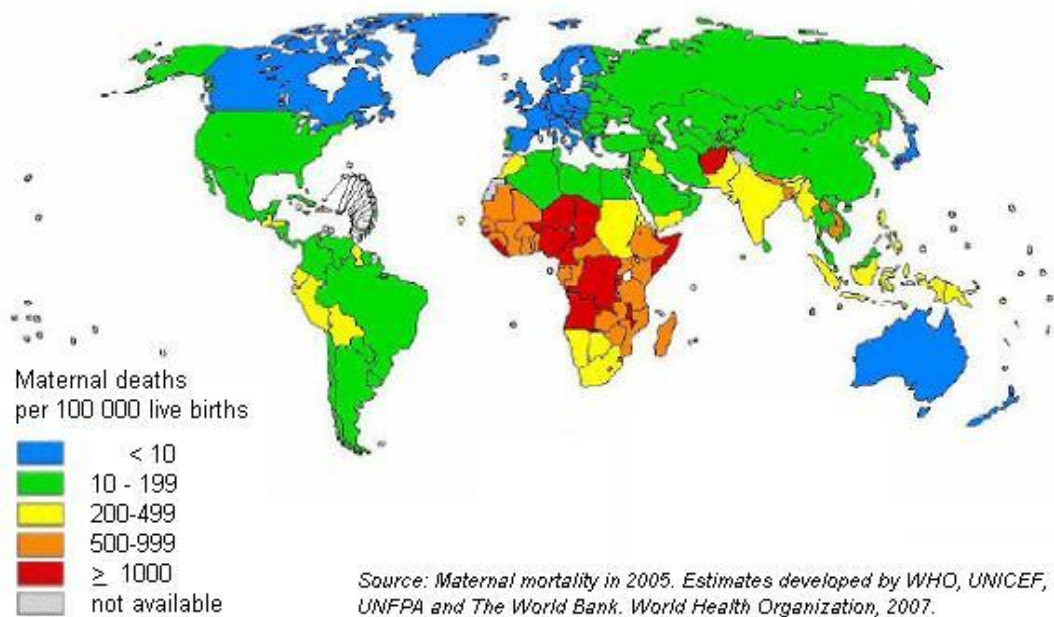


Figure 2: Maternal mortality by country (World Health Organization 2007)

Improving maternal health and reducing maternal mortality is more than just a development issue however. The fact that most of these deaths can be prevented reflects broader human rights violations unevenly affecting excluded members of society (Hunt and Bueno de Mesquita 2010). Despite improvements to maternal health in many countries, maternal mortality and morbidity continue to pose a significant threat to millions of vulnerable women (World Health Organization 2014a). Women in LMICs, in particular those who come from ethnic or other minority groups and lower socio-economic classes, are at greater risk of experiencing life-threatening complications as a result of pregnancy or childbirth (Countdown to 2015 2011). This is indicative of the broader social problems affecting men and women with limited access to power or resources. Inequities between those with financial security and those who are otherwise excluded, particularly between the rich and the poor or between men and women, are at the core of maternal mortality and morbidity, and subsequently influence the availability, accessibility, and quality of maternal health services (Realizing Rights: The

Ethical Global Initiative 2010). Maternal mortality can therefore serve as an important indicator of the functionality of a health system as well as the social and structural determinants of the health of vulnerable populations (World Health Organization 2014a).

2.3.1 Problems in Maternal Mortality Research

The past few decades have generated much empirical and theoretical literature concerning maternal mortality. However, despite the influx of research and the resulting global initiatives, the solutions to maternal mortality continue to remain ambiguous in much of the world (Gil-Gonzalez et al. 2006). Although many maternal deaths are avoidable, standard programs to improve mortality rates in LMICs have often been poorly implemented or ineffective in controlling the causes of maternal mortality (Gil-Gonzalez et al. 2006). Further, obtaining complete information about the causes of maternal mortality has not been possible given the inadequacies of data collection systems in various countries (Say et al. 2014). Nevertheless, understanding the causes of maternal deaths is a key requirement for developing effective policy and successful health programs (Say et al. 2014).

Scientific research on maternal mortality has historically been focused on clinical factors such as hemorrhage or hypertensive disorders. Accordingly, following the influential systematic analysis of all available published scientific research on the causes of maternal deaths that was published by Khan et al. in 2006, clinical factors such as these have been consistently named as the leading direct causes of maternal deaths (Gil-Gonzalez et al. 2006; Khan et al. 2006; Say et al. 2014). This approach however, does not allow for a holistic understanding of the broader economic, social, political and structural factors contributing to high maternal death rates. More significantly, the clinical focus can reflect a lack of commitment to gender inequalities and women's reproductive health needs. For instance, maternal mortality, as defined by Say et al. (2014, p.e323) refers to “the death of a woman whilst pregnant or within 42 days of delivery or termination of pregnancy, from any cause related to, or aggravated by

pregnancy or its management, but excluding deaths from incidental or accidental causes.” This definition implies that the causes of maternal deaths are clustered around labor, delivery and the immediate postpartum (Ronsmans and Graham 2006). The actual causes of maternal deaths, however, extend beyond this time period and are more often the result of weak health systems and unequal access to safe and acceptable health services (Filippi et al. 2006). Experiencing a safe and healthy pregnancy is therefore more than a clinical issue, but a human rights issue where maternal mortality and morbidity are derived from social exclusion and thus coincide with unequal access to social citizenship.

2.4 Causes of Maternal Mortality and Morbidity

Maternal health is therefore more than just decreasing mortality and morbidity. It is about providing all women with equal access to quality maternal health services throughout pregnancy, childbirth and postpartum (also referred to as the continuum of care model) (Filippi et al. 2006). For a healthy pregnancy, safe birth and a healthy postpartum, women need access to a range of care services starting even before becoming pregnant. The continuum of care for reproductive, maternal, newborn and child health (RMNCH), a core principle of global programs for Maternal, Neonatal and Child Health (MNCH), highlights the necessity for “...integrated service delivery for mothers and their children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, through outpatient services and other health facilities” (Partnership for Maternal Newborn & Child Health 2011, p.1). Providing comprehensive care covering all stages along the continuum is known to be a necessary strategy to improving maternal health (Koblinsky et al. 2006). Unfortunately, current patterns of care in the poorest parts of the world do not always follow this strategy.

Women in remote resource poor areas, in particular, are less likely than their high income urban based counterparts to have access to family planning, antenatal care visits, skilled birth attendance and postpartum care (World Health Organization 2014a).

Despite global tendencies to highlight the importance of facility based care, nearly one in four women in LMICs gives birth at home, either alone or with a relative or neighbor present to assist them (Koblinsky et al. 2006). Some of the factors that prevent women from seeking or receiving care prior to and during pregnancy, childbirth and the postpartum are poverty, geographical distance, lack of information, inadequate services, and differing cultural practices or maternity beliefs (World Health Organization 2014a). Indirect causes such as these have generally been attributed to the “three delays”: *1) the delay in recognizing when an expectant mother needs care and thus deciding to seek care, 2) the delay in reaching care in time, and 3) the delay in receiving quality care in health facilities* (Thaddeus and Maine 1994). The third delay occurs at the facility and may be due to a number of systemic barriers, such as staffing shortages or poor quality of care. Some scholars have also referred to a critical fourth delay contributing to high rates of maternal mortality: *4) the delay in the community accountability of maternal health services*¹² (Catalysts for Change 2010; Pathfinder International 2015).

Maternal mortality rates and patterns of care vary across countries and are influenced by a number of socio-economic conditions specific to each area. Obstetric risk, or the probability of a woman dying once she becomes pregnant, is far higher in sub-Saharan Africa and Southeast Asia than in other regions such as Europe or North America. In 2000, for example, the MMR in sub-Saharan Africa was estimated to be nearly 1000 per 100,000 live births, while in high income countries such as the United States, the MMR is as low as 15.1 deaths per 100,000 live births (Gaskin 2008; Ronsmans and Graham 2006). Further, in many countries, maternal mortality is inversely proportional to the status of women (Filippi et al. 2006). As women in many LMICs often have less freedom and personal autonomy in comparison to men, their ability to access maternal health services and family planning can be limited (Filippi et al. 2006). In Benin, for example, the cost for maternity services is covered by men as a way of acknowledging paternity (Filippi et al. 2006). Issues of gender equality and differing cultural norms are

¹² The role of community accountability will be described in more detail in Chapter 3 (Section 3.7) of this thesis.

thus also closely related to causes of maternal deaths. Maternal mortality (in these areas) is therefore not just a matter of clinical complications, but is indicative of greater societal inequalities adversely affecting women of lower socio-economic status.

2.4.1 Emphasizing Facility Based Care

The current emphasis in maternal health research calls for the increased use of skilled birth attendants and facility based care. Evidence from around the world shows that chances of survival for mothers and infants are greater if comprehensive obstetric care is available (Koblinsky et al. 2006). Accordingly, it is seen as increasingly important for mothers to give birth in health facilities and in the presence of a skilled health professional in order to ensure the timely management and treatment of complications should they arise (World Health Organization 2014a). Emphasizing facility based care however, seems to grant privilege to the medical model of care over alternative models. Consequently, privileging a medical model of care can imply additional normative assumptions concerning rights of knowledge. The medical model, for instance, is based on western notions of physiological symptoms and aims to find causes and remedies of these symptoms (Laing 1971). Alternative models, such as holistic or traditional health systems which are used by many cultures around the world, may resultantly be seen by health professionals as less important or not taken as seriously. The tendency to emphasize the medical model in health facilities over alternate models of health further highlights the ways in which power imbalances mediated by the SDH can influence access to health care, negatively affecting those who are excluded over those who are not. This then raises problematic questions over whose knowledge system is or should be given more credibility, those who hold greater power, or those who do not (i.e., the excluded)?¹³

Nevertheless, current evidence suggests that most maternal deaths occur between the third trimester and first week following childbirth (Ronsmans and Graham 2006). As such, keeping women at close proximity to professionals who can spot the first signs of

¹³ These issues will be discussed in more detail in the following subsection 2.4.2 of this chapter.

complications is extremely important. Despite this knowledge, there has been a slow uptake in the use of institutional care in many regions (Koblinsky et al. 2006). This slow uptake is likely indicative of women underutilizing services either out of necessity or choice. In sub-Saharan Africa, for instance, many women want to visit health facilities, however many areas in this region face significant shortages of health providers and facilities with functioning emergency obstetric care (Koblinsky et al. 2006). The absence of professional care therefore poses a major barrier for women facing obstetric risk. In other regions where services may be available but underused, women face having to choose between avoiding poor quality health services and possibly giving birth at home, or utilizing health facilities where they would receive poor quality of care. In Bolivia, for example many women speak of being shamed and embarrassed while receiving maternity care, often citing demeaning language by health personnel and being ridiculed for their clothes, poverty and hygiene (Koblinsky et al. 2006).

Despite the current emphasis to increase facility based care, some studies show that of the women who die, many do so in the hospital itself (Ronsmans and Graham 2006). The proportion of women who die in hospitals generally include "...three main types of cases: women who arrive in a moribund state too late to benefit from emergency care, women who arrive with complications who could have been saved if they had received timely and effective interventions, and women admitted for normal delivery who subsequently develop serious complications...and die with or without having received emergency care" (Ronsmans and Graham 2006, p.1195-1196). Of these three types of cases, the latter two indicate that the problems may have been exacerbated due to poor quality of care. Evidence suggests that delays by providers (coinciding with the third delay as described in Section 2.4) in recognizing life-threatening complications can thus also be a (direct) cause of maternal deaths (Ronsmans and Graham 2006). The examples from sub-Saharan Africa and Bolivia both present clear cases of exclusion and health inequalities influenced by the SDH, where women in LMICs face discrimination as a result of varying social, cultural and institutional barriers. Given the importance granted to facility based care in current maternal health programs, global maternal health

professionals should be equally concerned with the quality of care at the facilities themselves. Likewise, pushing the medical model onto groups who may not usually prefer this type of care implies that their alternate beliefs over health may not be as valid or credible as those favored by western educated health professionals. The dominance given to the medical model can therefore have the (albeit unintended) result of reinforcing power imbalances between groups and thus reinforcing inequalities.

2.4.2 Integrating Traditional and Biomedical Approaches

Throughout the history of maternal health programs, there have been fluctuations as to the degree to which traditional approaches to maternal health care have been included alongside the emphasis of facility based care (Byrne and Morgan 2011). In the 1970's for example, global maternal health programs called for the inclusion of traditional birth attendants (TBAs) in regions with high maternal mortality rates (Byrne and Morgan 2011). In countries where home births aided by traditional healers or shamans are preferred, the institutionalized use of TBAs seemed like a viable solution. However, after two decades of formally training and deploying TBAs, there were still minimal MMR reductions (Byrne and Morgan 2011). Some of the limitations of including TBAs were that despite being trained, they were still ill-equipped to handle life threatening emergencies (Byrne and Morgan 2011).

Recognizing the limitations of TBA programs, global maternal health professionals started shifting toward the inclusion of skilled birth attendants (SBAs). Since the introduction of SBAs into maternal health programs, skilled birth attendance has increased to 66% globally (Byrne and Morgan 2011). Despite this increase, many women in LMICs continue to either give birth at home alone or rely on TBAs (Byrne and Morgan 2011). As a result, several studies have examined the challenges specific to regions with integrated approaches to maternal health care. One study in Zimbabwe, for instance, argues that though many women rely on TBAs as a result of the severe shortage of skilled health professionals in the country, government policies appear to "...relegate them to the fringes of healthcare provision" (Zorodzai Choguya 2014, p.1).

The TBAs in this case are a lifeline for many women who cannot access skilled health professionals; however the government does not show evidence of formally incorporating TBAs into the health system (Zorodzai Choguya 2014). As such, in regions where the formal health system does not always meet the needs of the population (e.g., as a result of staff shortages or differing cultural preferences to care), integrating traditional approaches, with the formal health system might be the key to improving maternal mortality rates.

Integrating pluralistic health systems is particularly important in regions such as the Peruvian Andes where there are vast cultural and traditional differences over pregnancy and childbirth practices.¹⁴ Implementing culturally adapted childbirth facilities in birthing hospitals (such as providing women with the option to give birth vertically), can be more appealing to indigenous women, and therefore boost the quality of care within the facility. The issue that is often ignored, however, is that this may again be privileging the medical model, in that failures to implement these policies may suggest that health professionals expect indigenous women to adapt their own health beliefs rather than finding a way for health professionals to take more consideration of the potential value for traditional health models. Consequently, this is another clear example of how inequalities are perpetuated by those who hold greater power, in this case, those within the health facilities. Given such issues, global health professionals have continued to find alternate approaches to encourage the utilization of facility based care in order to improve maternal health among excluded communities. One such approach has been to develop Primary Health Care as will be described in the following section.

2.5 Primary Health Care and Community Health Workers

Primary Health Care (PHC) as a strategy to attain “health for all by the year 2000” gained prominence at the International Conference on Primary Health Care that took place at Alma-Ata, Kazakhstan in 1978 (Cueto 2004; van der Geest et al. 1990).

¹⁴ This is discussed in more detail in Section 1.2 of the previous chapter and throughout the remainder of this thesis.

According to the Alma-Ata declaration that was developed following the conference, PHC refers to:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (World Health Organization 1978)

PHC can thus generally be defined as an approach to health care beyond the health system that focuses on producing health equity at the community level (Starfield 2011). The key principles of PHC as detailed during Alma-Ata include:

1. Care should be aimed at the most needy groups.
2. PHC should include a range of essential, appropriate activities.
3. Care should be accessible and acceptable to everybody.
4. PHC should be affordable.
5. There should be full community participation.
6. PHC should be integrated with other health levels and with other development sectors.

At the time of Alma-Ata, the global health community seemed enthusiastic about implementing a comprehensive community based health care approach to meet all of these above principles. It wasn't long after, however, that critics started vocalizing their concerns. One of the main concerns raised was that PHC seemed to be too idealistic and not feasible for the time period (van der Geest et al. 1990). Indeed, in the years

following, many countries continued to struggle to provide health equity or universal health coverage for their populations (World Health Organization 2008). Despite the failure to fully attain “health for all” by the 2000 deadline, many countries continue to provide national PHC plans (World Health Organization 2008). Most of the PHC plans which have been developed include community health workers (CHWs) as a central component and many countries have in the past had considerable experience running CHW programs as will be described in more detail in the following subsections of this chapter (2.5.1 and 2.5.2) (Heggenhougen et al. 1987).

The tendency to emphasize PHC as an aspect of development occurred in part as a reaction against the apparent disregard for the social effects of development by some writers in the 1950s and 1960s (Walt 1990). At the time, the popular notion among development professionals was that LMICs were “developing,” or “...as yet unformed, infant versions of modern Western societies” (Walt 1990, p.4). In the years following, however, some studies started suggesting that the implementation of development projects which aimed to “westernize” poorer nations was having the unexpected consequence of causing recipients ill health and exacerbating economic inequity between the rich and the poor (Hughes and Hunter 1970; Walt 1990). Following this shift, development professionals started paying more attention to the relationship between poverty, inequality and health, thus leading to a greater focus on PHC and community health projects (Walt 1990).

The PHC projects that were designed started to view health work as more than just short-lived isolated events. Vertical programs focusing on infectious diseases, such as Malaria eradication strategies were no longer seen as effective in meeting people’s wider health needs. Instead, through PHC, health work was perceived as a process of improving daily living conditions, such as those mediated by the SDH (Cueto 2004). This arose in part from disillusionment with the medical model which dominated previous health and development programs (Walt 1990). Critics of the medical model emphasized the importance of community health strategies rather than focusing on the

individual, arguing that approaches to health care should be culturally appropriate and sensitive to the SDH (Walt 1990; World Health Organization 2006).

Despite the necessary focus on community health over individual biomedical characteristics, development professionals began to point out several problems with the PHC strategy. Critics began to question how PHC would be financed and implemented and also how it was to be defined (Cueto 2004). For some, PHC was seen to be merely an extension of preexisting health services to rural areas which were second-care quality at best, while others viewed it as a precursor to social revolution (Cueto 2004). A solution that was offered to these problems took the form of selective PHC rather than comprehensive. Selective PHC emphasized attainable goals and cost-effective planning which took the form of low cost technical interventions aimed to combat disease problems specific to poor populations (Cueto 2004). Selective primary health care began to attract the support of some donors and according to some "...it created the right balance between scarcity and choice" (Cueto 2004, p.1869). Others however were quick to criticize selective PHC in the 1980s due to a number of reasons. Growth monitoring programs, for instance, were said to have become too focused on attaining the correct figures rather than serving as a means to improve nutrition among vulnerable children (Cueto 2004). Breastfeeding programs also came under scrutiny because they were subject to propaganda from the food industry (Cueto 2004). As such, both PHC and selective PHC have experienced waning popularity in recent decades. Nevertheless, PHC programs are still included in many Ministries of Health, often coexisting with vertical health programs and thus warrant more detailed inquiries into their successes and failures.

2.5.1 The Development of Community Health Worker Programs

The implementation of PHC programs following Alma-Ata also gave rise to the use of national CHW programs in many countries. The idea behind the formulation of national CHW programs was to involve community members in providing PHC services within their own communities (Heggenhougen et al. 1987). In this way, PHC could be

delivered by individuals who have firsthand experience understanding the specific needs of their own communities (Lehmann and Sanders 2007). Known around the world by many different names (e.g., Health Promoters in Peru, Lady Health Workers (LHWs) in Pakistan), CHWs are mostly voluntary, or semi-voluntary and are provided minimal training in basic preventative and curative health care (Heggenhougen et al. 1987).

Though varied from place to place, the general requirements to become a CHW usually include literacy and coming from the same community in which they work (Bhattacharyya et al. 2001). The role and status of the CHW is also highly dependent on the gender, culture, religion or ethnic group of the communities in question. In many cultures, for instance, it is not socially acceptable for women to have contact with men or to travel alone to unfamiliar households. In regions such as these, the majority of CHWs are women. However, at the same time, some cultures may place more emphasis on age or gender rather than the amount of training received. In these cases, young unmarried women may not be seen as having any health knowledge despite undergoing training, thereby possibly resulting in more male CHWs than female (Bhattacharyya et al. 2001). The ramification of having more male CHWs is clear in the case of maternal health services in that it may become another limiting factor in the accessibility of services in areas where gender and modesty rules are traditionally followed.

The tasks expected of CHWs are also variable depending on the context and country. Some of the tasks listed during Alma-Ata for instance were:

Home visits, environmental sanitation, provision of water supply, first aid and treatment of simple and common ailments, health education, nutrition and surveillance, maternal and child health and family planning activities, communicable disease control, community development activities, referrals, recordkeeping, and collection of data on vital events. (Ofosu-Amaah 1983, p.10)

Such a wide range of tasks would not likely be feasible for voluntary workers. As such, many programs trained CHWs to work in a single area such as malaria, nutrition or TB/HIV (Bhattacharyya et al. 2001).

It is important also to recognize the distinction between CHWs and other professional health workers. Most professional health workers are educated at least to degree level and are generally paid a salary. CHWs on the other hand may not have formal education and are often employed part-time. Table 1, compares professional and volunteer workers from Latin America, which often generally applies to other countries.

Auxiliary nurses or health technicians (professional health staff)	Health promoters or village health workers (volunteers from the community)
<ul style="list-style-type: none"> ■ Primary education plus 1-2 years of training ■ From outside the community ■ Employed full time ■ Salary usually paid by the program (not by the community) 	<ul style="list-style-type: none"> ■ Third grade education plus 1-6 months of training ■ From the community ■ Employed part time ■ Supported by farm labor or other community help ■ May be traditional healers

Table 1: Comparison of CHWs with professional health staff (Walt 1990)

Despite some of the critiques of PHC programs as discussed above, several studies have shown that CHWs can positively influence morbidity and mortality rates in some settings (Bhattacharyya et al. 2001; Lassi et al. 2010; Lehmann and Sanders 2007; Walt 1990). This is because as one of the cornerstones of PHC, CHWs have the potential to help fill gaps in health services, such as through providing equitable care in rural areas or among communities where there are social and cultural boundaries to accessing care (Bhattacharyya et al. 2001). By providing simple technical and educational interventions, CHWs could also act as an agent of change in their communities on issues that affect health (Bhattacharyya et al. 2001). One of the main challenges in many CHW programs has however occurred when taking these programs to scale. In many cases, this has been a result of limited incentives available to CHWs as well as not having a clear definition of the specific tasks expected from them (Lehmann and Sanders 2007). This has resulted in many CHWs feeling unmotivated to carry out their work and thus

dropping out of programs (Lehmann and Sanders 2007). Challenges such as these are detailed in the following sub-section.

2.5.2 Problems and Challenges for CHWs Worldwide

Although CHWs have the potential to be an integral link between excluded and marginalized populations and the health system, there is worldwide evidence of certain challenges they face. For instance, expanding local programs to national scale is a significant area which still requires attention. Nevertheless, there has been some evidence of countries which have achieved national scale with their CHW programs, such as Pakistan, Thailand, Brazil, Ethiopia (Liu et al. 2011). These programs, which were included in the comprehensive review of global CHW programs released by the Global Health Workforce Alliance in 2010, were seemingly able to reach national scale by successfully achieving rapid deployment of CHWs (Bhutta et al. 2010). Pakistan's Lady Health Worker Program (LHWP), for instance is one of the largest CHW programs in the world, with an estimated 110,000 LHWs deployed since its establishment in 1994 by the Ministry of Health (Zhu et al. 2014). In Thailand, the government backed Village Health Volunteers (VHV) program counted on nearly 800,000 nationwide volunteers since its inception during the height of the Health for All movement (Jimba et al. 2010). Current estimates now place this number at over one million with each VHV working with between seven to twelve families in their designated communities (Swartz et al. 2015). The Agentes de Saúde of Brazil, launched following a major health crisis in the late 1980s hitting Ceará, the state with the highest rate of poverty in the country, has since been expanded and is now integrated into the National Family Health Program (Liu et al. 2011). A more recent example of rapid deployment of CHWs occurred in Ethiopia with the introduction of Health Extension Workers (HEWs) in 2004. The HEW plan, developed with joint support from the Ethiopian Federal Ministries of Health and Education, forms part of a wider Health Extension Program which was aimed to greatly expand the number of community level services and providers (Liu et al. 2011). Incorporating a system of training and staffing mid to high-level health care providers in

addition to new HEWs has since (as of 2009) resulted in the deployment of over 31,000 HEWs and over 3,900 district health offices (Liu et al. 2011).

The above four examples are provided to show how strong government support may lead to successful scale up of CHW programs. Indeed, a key success factor in all four countries has been the coordinated deployment of an expanded CHW network. Although notable, examples such as these do not address the sustainability of these programs. Strategies that emphasize rapid growth of national PHC coverage could very well potentially result in paying less attention to other elements of the program such as management capacity or quality of care. Weaknesses in management, for instance, can negatively influence CHW motivation and retention, incentives, infrastructure and other healthcare delivery domains. This likely occurs when attempts to scale up programs do not coincide with the relative strength of the wider PHC system as indicated in the following excerpt:

Laying a community health worker program at scale upon an uneven or underdeveloped primary healthcare system increases the risks of program failure across many domains of effective healthcare delivery, including but not limited to supervision, infrastructure, capacity, supplies, information systems, process improvement, and human-resource capacity of higher-level providers. (Liu et al. 2011)

Another challenge to the development of successful CHW programs occurs in regions where there is more than one preferred model of health care. In pluralistic health settings where traditional and biomedical approaches coexist (as discussed in Section 2.4.2 of this chapter), it is significantly important to develop and implement socio-culturally appropriate interventions that work for all involved parties. This means that in addition to government support, it is also up to the community, the CHWs, formal health providers and NGOs to ensure that these programs are implemented and widely known about. Research by Bristow (2005; 2008) for instance, examines the role of NGOs in managing and training CHWs to incorporate combined elements of health care provision in the Bolivian Andes. In one example she explains how indigenous knowledge is often ignored which can lead to missed opportunities to improve health care:

...in relation to [diarrhea]...the main concern is to prevent dehydration by giving oral fluids. In Andean medicine, mothers bathe their children in herbs, giving only small amounts of fluid orally. It is not hard to imagine that if the value of both medical systems were acknowledged in practice, as well as in policy, biomedically trained health workers might be able to communicate the importance of increasing oral fluids alongside bathing in herbs. (Bristow 2005, p.246; Bristow 2008; Nichter 1988)

Thus, as the above example states, health workers (including CHWs) who are biomedically trained can bring important information back to their communities while at the same time recognizing the value of western biomedical approaches. Nonetheless, recognizing the value of both systems should also be present in formal institutions, such as the health system and government agencies if CHW and other PHC programs are expected to work.

2.6 Conclusion

This chapter has provided a discussion of social exclusion and the social determinants of health and how these contribute to maternal mortality worldwide. Some of the problems associated with maternal mortality research were examined as well as some of its causes and approaches aimed to improve maternal health in LMICs. One key approach that gained popularity following the Alma-Ata conference in 1978 was that of primary health care, including the implementation of community health workers to serve as local level care providers. An overview of primary health care and community health worker programs was therefore provided as well as some of the problems and benefits associated with these programs. As such, this chapter has demonstrated that while primary health care approaches to improving community health in LMICs have as a whole been considered beneficial, they have also faced many problems. For this reason, this study is intended to gain an in-depth understanding of the role of CHWs in maternal health in one particular setting. The following chapter thus provides a literature review of indigenous exclusion, Andean maternal health and the role of CHWs within this context.

Chapter 3: Indigenous Exclusion and Andean Maternal Health

3.1 Introduction

Drawing from the concepts explained in the previous chapter, this chapter examines the development and potential causes of social exclusion and maternal mortality in Peru's Andean communities. Latin America in general has a long history of income inequalities and social exclusion which are, in turn, reflected by high maternal mortality rates throughout the region (Bianco et al. 2011). Figure 3, for example, shows maternal mortality rates in South America as of 2013.

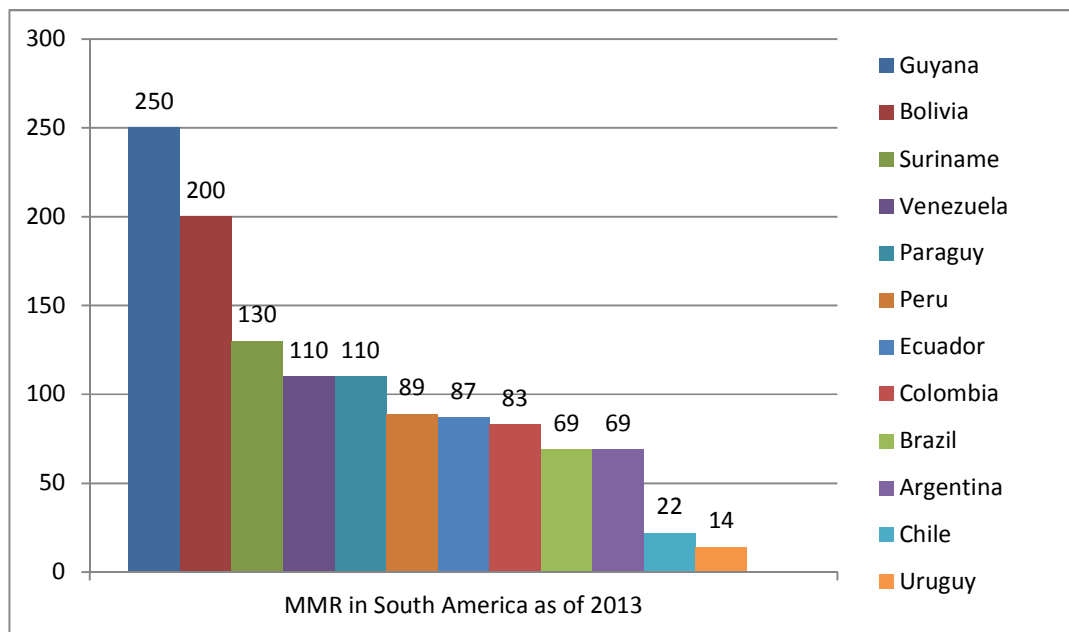


Figure 3: Maternal mortality rates (per 100,000 live births) in South America (World Bank 2014)

Peru, a country which previously held the second highest maternal mortality rate in South America,¹⁵ reflects the significant social and systemic inequities faced by the indigenous population, in particular, indigenous women living in remote or rural

¹⁵ Recent economic growth has contributed to significantly improving Peru's MMR. Peru's current MMR is 89, however this number is likely much higher given reporting problems in rural regions such as these. When this study commenced, Peru's MMR (210) was only second to Bolivia, who now currently holds the second highest MMR (200) in South America. As of 2012, Guyana has the highest MMR in the region (250) (World Bank 2014; World Health Organization, UNICEF, UNFPA and The World Bank 2012).

communities (Physicians for Human Rights 2007). Such inequities are deeply rooted in the social and historical experience of the nation, which has led to severe structural violence and institutionalized racism within the health services themselves (Physicians for Human Rights 2007). Accordingly, this chapter begins by describing the social and historical context of Peru (3.2). Included in this discussion is an explanation of the geo-political divisions and social structure of the nation. A conceptual examination of ethnicity, culture and race is then provided (3.3), including a discussion of some of the current debates concerning theories of Andean identity construction. Section 3.4 provides an overview of the history of exclusion in Peru. A discussion of maternal health services in rural Andean communities is then provided which explains the types of services provided to pregnant and postpartum women, and examines the availability, accessibility and quality of these services (3.4). The penultimate section (3.7) of this chapter discusses community level approaches to meeting maternal health care needs and examines the development of CHW programs operating in Peru's Andean communities. Section 3.8 concludes this chapter.

3.2 Country Context

The following subsections provide some background information on the geo-political and social context of Peru and the study site.

3.2.1 Geography and Demographics

Geographically, Peru is divided into three distinct regions: the desert coastline in the west (*La Costa*), the highlands of the Andes mountain range in the center (*La Sierra*), and the Amazon Rainforest in the East (*La Selva*) (Figure 4). Approximately 27% of the population lives in rural areas, mostly in the Andean region,¹⁶ while the majority of the population lives in urban areas of the coastal region (World Population Review 2014). At an estimated thirty million inhabitants, Peru has the 42nd largest population in the world and the fourth largest population in South America (World Population Review

¹⁶ There are rural indigenous communities in the rainforest as well, however due to time limitations of this study, native peoples from this region have also not been included.

2014). Given its multiethnic population, Peru has historically been divided into four main ethnic categories: 1) *Criollo* (of white European ancestry), 2) *Mestizo* (of mixed European and Amerindian ancestry), 3) Amerindian or Indigenous¹⁷ (those native to the region prior to the arrival of the Spanish), and 4) a smaller “other” category including Japanese, Chinese and Afro-Peruvians (of African descent). Although they are considered a minority group, the Amerindian population is the largest in the nation, consisting of an estimated 45%. The mestizo population comes in second with approximately 37%. *Criollos* and Peruvians belonging to the “other” category make up around 15%, and 3% percent, respectively (Figure 5). As described, about two-thirds of Peru’s population resides in urban coastal centers and the remainder is in the Andes. The Amazon is the least populated region of Peru¹⁸ (Minority Rights Group International 2007; The World Factbook 2009). Approximately 45% of the population is indigenous with an estimated five million native Quechua speakers, most of who live in the Andean region of the country (Physicians for Human Rights 2007; World Population Review 2014).¹⁹

¹⁷ This thesis uses the term Amerindian and Indigenous interchangeably.

¹⁸ Although the Amazon is also home to a predominantly indigenous population, due to vast cultural and geographical differences, these groups are not within the scope of this study and therefore not included.

¹⁹ There are also a large number of Aymara speakers who live in the altiplano but these have also been excluded from this study due to time and financial limitations.



Figure 4: Map of Peru depicting the three main geographical areas (Migueluez 2009)

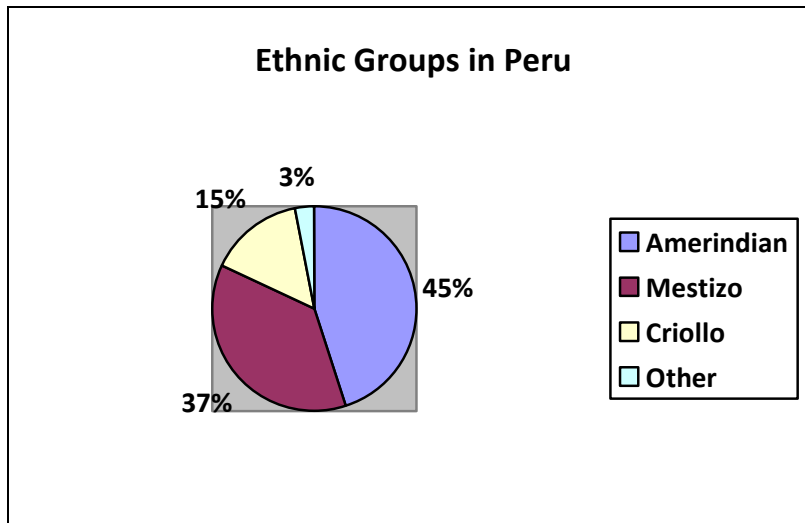


Figure 5: Ethnic groups in Peru

Although it is a middle income country, over half of Peru's population lives in poverty and approximately 24% live in absolute poverty, meaning they survive on less than US\$1.25 a day (Amnesty International 2009a; Physicians for Human Rights 2007). The distribution of poverty is disproportionate, however, with approximately 57.7% of those who live in poverty coming from rural areas, while only an estimated 9.7% live in urban areas (Amnesty International 2009b; Physicians for Human Rights 2007). Peru's rural indigenous population makes up the majority of those living in poverty and absolute poverty (Physicians for Human Rights 2007). According to government statistics, for example, the national rural poverty rate is over 50%, with 20% of the people living in the Andean region considered extremely poor (Rural Poverty Portal n.d.).

3.2.2 Political Divisions of Peru and the Study Site

Modern-day Peru is divided into 25 regions, 195 provinces and 1,833 districts (Gobierno del Peru 2012). In rural areas, these divided administrative regions are generally characterized by an urbanized capital consisting of a main plaza bordered by a church and municipal government office (Hudson 1992). The majority of Andean rural areas are

made up of small *campesino* (translated as “rural community member” and often synonymous with “peasant”) communities whose ancestral origins date back to pre-Inca Peru (Food and Agriculture Organization n.d.). The Cusco Region (Figure 6), where this study was conducted is located in the southern highlands of the country and is itself made up of 13 provinces, including Cusco City which is the capital of both Cusco Region and Cusco Province (Figure 7).



Figure 6: Map of Peru highlighting Cusco Region (Huhsunqu 2010)



Figure 7: Map of Cusco and its provinces (Againerick 2007)

As the historical capital of the Inca Empire, Cusco is a site of tremendous significance for Peruvians, not only in regards to its cultural and historical importance, but also as one of the country's most substantial sources of tourism, and therefore national revenue. Foreign interest in the region has, however, held implications which go beyond economic gain. Attempts to promote tourism have had a notable impact on the ways in which the region's inhabitants are represented and equally represent themselves. Symbols of national identities drawing on Cusco's heritage, such as Inca statues or indigenous costumes, have frequently been used as a way to market indigenous cultural products, thereby increasing transnational tourism. In this regard, indigenous identities in this area, having encountered such processes of commodification, have been distinctly shaped in relation to those of the rest of the country²⁰ (Garcia 2005).

3.2.3 Peru's Social Structure

²⁰ Indigenous identities in the Andes will be discussed in more detail in Section 3.3 of this chapter.

The social structure in Peru is characterized by a wide gap between rich and poor (Physicians for Human Rights 2007). Deep class divisions have been documented throughout the nation's history and are said to have started "...with the hierarchical principles set down in colonial times that remain as powerful guidelines for intergroup and interpersonal behavior" (Hudson 1992, Ch.3). Class divisions reminiscent of Peru's colonial caste system²¹ are viewed to occur between different social groups on the basis of socio-economic status. Although the social structure of Peru does not operate under a formal caste system anymore, it has been argued that an implicit caste system is still present (Benavides 2014). This is most evident in the ways the indigenous Andean population is treated, with many being excluded due to racial discrimination. Peru's class hierarchy is strongly two tiered and divided by ethnic and racial attributes (Hudson 1992). The greater socio-economic opportunities, such as greater access to education, employment or other aspects of social citizenship, that are granted to the *criollo* or *mestizo* population over indigenous Peruvians has, for example, historically often been determined by a person's skin color, cultural practices and ethnicity (de la Cadena 2000).

While Cusco is recognized throughout Peru as a source of national importance and pride, there is at the same time a discernible polarity in attitudes towards its inhabitants. Contrasts between the coastal areas, in particular Lima with its political and economic control, and the highland Andean regions (as well as the lowland Amazonian basin) with relatively higher levels of poverty and inequality, are evident not only through their geographic differences, but also equally reflective of the distinct cultural, ethnic and class divisions permeating the social structures of the country. Thus, despite Cusco's popularity, many urban *Limeño/as* (Lima residents) still view Cusco residents (*Cusqueño/as*) and other Andeans as inferior (Garcia 2005). Cusco and Lima, accordingly, can be seen to embody opposing ideologies of national identity. With Cusco representative of Peru's pre-colonial Inca past, and Lima viewed as the country's

²¹ Peru's colonial caste system will be discussed in more detail in Section 3.4 of this chapter.

cosmopolitan center, and therefore equated with progress, tensions over representations of Andean and indigenous identities have in some instances been regarded as corresponding to the social and economic disparities evident in the country, and more specifically in Cusco itself (Valcárcel 1978 [1927]).

Such tensions are consequently manifested in structural and institutional systems of inequality, for instance those which occur within the national health system, and have influenced the ways in which health services are provided and utilized throughout Andean regions (Physicians for Human Rights 2007). Not surprisingly, the majority of health professionals and government employees working throughout Peru are of *criollo* or *mestizo* background (Physicians for Human Rights 2007). As a result, health inequalities may often be reinforced when the only option for indigenous Andeans in need of health or other social services is to seek services from institutions that consist of employees from ethnic and socio-economic groups separate from their own (Benavides 2014).

Though some *Limeño/as* and other urban residents hold negative attitudes towards highland Peruvians, it would be fit to assume that local services in communities of Cusco, particularly those located in the area known as the Sacred Valley, would benefit from the high levels of national and external interest it experiences. The Sacred Valley, similarly to Cusco, is a site of both historical and modern significance. Formed by the Urubamba River and located below the renowned Inca city of Machu Picchu, the area is considered the heartland of what was the Inca Empire and therefore lies directly on the tourist path (Bauer and Covey 2002). Nonetheless, communities falling in the periphery of the pre-colonial sites often receive minimal attention in relation to those closest to the more visited areas (Bauer 1999). Despite their proximity to these heavily frequented locales, inhabitants of remote mountain communities of the Sacred Valley are generally isolated, facing extreme levels of poverty and lacking basic social services such as medical care (Amnesty International 2009a; Amnesty International 2009b; Garcia 2005).

Rural communities in the province of Calca (Figure 8), where this study took place, often encounter a considerable amount of neglect in terms of the availability, accessibility and quality of health and social services (Dirección Regional de Salud Cusco 2008). Situated along the northern edge of the Sacred Valley, Calca Province encompasses some of the poorest areas of the country (Red de Gestores Públicos 2012). As one of thirteen provinces in Cusco Region, it covers an area of just over 3,625 kilometers and is made up of eight districts. The capital of the province, a town also by the name of Calca is located 52 kilometers north of Cusco City and lies at an elevation of 2,925 meters above sea level (Ministerio de Comercio Exterior y Turismo 2008; Promo Región Cusco 2013). The entire province has a population of at least 65,407 registered inhabitants, while the district of Calca, including the capital, has a population of 19,312 (Promo Región Cusco 2013). The other seven districts within the province have populations spanning from 3,705 to 10,959 inhabitants (Promo Región Cusco 2013).



Figure 8: Map of Calca Province (Valderrama 2005)

Communities in Calca, thus range from extremely rural and isolated mountain settlements or villages to small rural towns, such as the capital. The majority of rural inhabitants are monolingual Quechua speakers, while some residents of the more populous areas, in particular men, speak both Quechua and Spanish. Given the extreme remoteness and high altitude of many of the communities, indigenous peasants, or *campesinos* as they are referred, living in these cold and arid regions, sustain themselves

primarily through subsistence agriculture and stockbreeding (Garcia 2005). In addition to farming and small-scale goods exchanges in the local village or district markets, the main source of income for Calca's *campesinos* is through the sale of hand-made textiles such as ponchos, hats and other garments (Valderrama Escalente 2006). Rural communities in the province are thus characterized by geographic isolation and harsh living conditions, resulting in limited access to medical facilities and services (Dirección Regional de Salud Cusco 2008). With limited access to the health system and therefore formal maternal health services, indigenous Andeans living in areas such as these more frequently experience poor health outcomes, which in turn often coincide with poverty and lowered social status (Amnesty International 2009a).

3.3 Ethnicity, Culture and Race in the Andes

To understand some of the factors contributing to exclusion, poverty and health inequalities resulting from divisions between different social groups in the Andes, it is first important to examine the interrelated concepts of ethnicity, culture and race. Though these different but closely linked terms may be used to explain different dimensions of the social order, their true conceptual meanings are often clouded in confusion. The simplest ways to define each would be to say that *ethnicity* refers to a social group's ancestral connection to a shared past and culture, with *culture* referring to the specific customs, norms and values of a particular social group, and *race* referring to an external classification of an individual's biological make-up (Boundless 2015). In other words, race is often considered a broader concept more closely linked to biological attributes, while ethnicity is more closely linked to cultural attributes expressed by language or religion. Theoretical debates over these terms, however, indicate that they are much more complex than the above definitions. In anthropology literature for instance, ethnicity is defined as:

...the community of individuals that share cultural elements and that organize their daily life around these. Generally it is associated with the idea of native communities that are isolated or that have a reduced contact with other communities. In urban settings, ethnic characteristics are associated, in a complex

and hotly debated relationship, with culture, religion, language, traditions and race, among other dimensions. (Torero et al. 2004, p.2)

Race of course is often also a hotly contested subject and can be morally challenging. “Racism”, a derivative of the term “race”, for instance, is understood as a term promulgating abuse, in that it consists of prejudices and discrimination based on the biological attributes of different groups (Ballard 2002). While race and ethnicity have historically been used interchangeably in older social science literature, more contemporary works view them as separate phenomena (Kuper 1999). Race, in this case emphasizes “...the common genetic characteristics of the entire spectrum of humankind...” (Ballard 2002, p.2). Under this definition, as far as contemporary science is concerned, there is only one human species and therefore only one human race (Ballard 2002). Despite this understanding of race, racism is still prevalent in many human societies. If race is conceived as an entity different from ethnicity, there must be some set of defining characteristics which contribute to racial diversity and thus racism. Accordingly, the diversity between different human populations eventually came to be understood as a result of social processes, or *culture* (Banton 1977).

In contrast to ethnicity and race, Kuper stresses the role of *differences* when it comes to understanding culture. He writes, “...culture is not a matter of race. It is learned, not carried in our genes...” (Kuper 1999, p.227). As such, culture can be understood as a concept that governs the rules and conventions in which human behavior is organized (Ballard 2002). It is socially transmitted among and between groups and can be represented by language, religion, social relationships and other forms of human interaction (Fedorak 2007). In contrast to early definitions of race, culture, as Ballard (2002, p.12) describes involves cognitive structures that can best be understood as “...the set of ideas, values and understandings which people deploy within a specific network of social relationships [and] use as a means of ordering their inter-personal interactions and hence to generate ties of reciprocity between themselves.” It can be argued therefore that culture, and equally ethnicity, are human constructs that are

constantly changing and subject to the interpretation of those who are using it (Ballard 2002).

The relationship between ethnicity, race and culture is one which is analytically problematic. In Peru, for instance, discrimination is a prevalent and accepted part of society and is more often attributed to cultural attributes, rather than ethnic or racial characteristics (Beall and Piron 2005; Figueroa and Barrón 2005). A potential assumption under this argument would then be that indigenous Andeans are not being discriminated against for their biological differences, despite the fact that it is often their shared biological characteristics (e.g., skin color) which visibly separate them from non-indigenous members of society. The reasons for this warrant further examination and potentially lie in the way identity is classified and perceived in Andean regions.

Ethnicity, culture and race make up three key forms of identity classifications in the Andes. The Latin American region in general is widely known to consist of a diverse ethnic and cultural population influenced by centuries of domination, immigration, and globalization (Benavides 2014; D'Andrea 2007; Figueroa and Barrón 2005). Given its diverse population, Peru in particular is characterized by ethnic, cultural and racial tensions (Van den Berghe 1977). Although exclusion characterized by discrimination against indigenous Andeans in the region has historically been attributed to cultural differences between the different ethnic groups, there has been limited consensus by scholars regarding how ethnic identities are defined. Comparative political scientists such as Horowitz (1985), for example, use ethnicity as a broad umbrella term encompassing any number of groups characterized by skin color, language, and religion (Chandra 2004; Htun 2004; Posner 2005; Varshney 2002; Wilkinson 2004). On a global scale, applying these characteristics towards defining ethnic identity favors classifying ethnic groups into specific categories such as “tribes”, “races”, “nationalities” or “castes” (Chandra 2006; Chandra 2006; Horowitz 1985). Despite such a broad usage of the term among scholars such as Horowitz, Chandra (2006, p.3) states that, “many comparative political scientists do not define the term before using it, and those who do often classify an identity as ethnic even when it does not correspond to their own

definitions.” Horowitz (1985), for instance, primarily defines ethnicity in terms of a shared common ancestry; however some of the ethnic classifications he uses in his research, such as Hindus and Muslims in India, or Creoles and Indians in Guyana do not necessarily correspond to this definition of shared ancestry (Chandra 2006; Horowitz 1985). Fearon and Laitin (2000) also define ethnicity on the basis of shared common ancestry. The descent rule, as they have identified states that “...all that is necessary to be counted as a member of an ethnic group is to be able to have accepted the claim to be immediately descended from other members of the group” (Fearon and Laitin 2000, p.13). This definition is problematic however, because it leaves out important elements such as shared cultural traits (e.g., language, religious beliefs, and traditional practices) or the historical influences of group identities as is particularly relevant in the Andean context.

Developing a consensus on the definition of ethnicity is necessary because it allows scholars to evaluate and expand theories concerning ethnic identity without taking its meaning for granted (Chandra 2006). An interesting argument, again in the comparative political science discipline, maintains that ethnicity is important because ethnic identities have particular characteristics that explain social and political tensions which can be a result of a shared historical experience (Chandra 2006). This argument is important to understanding why discrimination and exclusion in the Andes are usually attributed to cultural differences rather than ethnic, in that the cultural practices and beliefs of indigenous Andeans have historically been considered inferior to those of the non-indigenous.²² Attributing discrimination solely to cultural differences, where differing cultural practices are often linked to shared ethnic heritage, thus undermines the historical and contextual nature of ethnicity and ethnic identity construction in Peru (Canepa 2008; Paredes 2007).

One such example of how socio-political events from Peru’s history have helped shaped the way discrimination based on ethnicity is experienced today occurred during the

²² This will be described in more detail in the following section of this chapter (3.4).

period of Spanish colonial domination. It has been argued that the Spanish conquest of the Inca Empire in 1532 resulted in the development of a parallel cultural shift among the Andean population (Hudson 1992). At the time of Spanish rule, Inca cultural traits, such as the Inca cosmology and language, were already firmly established in the Andean region (Hudson 1992). The Spaniards, with their new administrative center located in Lima, rather than the previous Inca capital of Cusco utilized their own cultural attributes such as the Spanish language and Catholicism as mechanisms of domination, causing a notable rift between groups which still appears today (Hudson 1992). Such a divide was characterized even more so through the varying ethnic, cultural and national identities which were developing. The descendants of Spanish colonizers continued to identify themselves as members of the Spanish nation, while indigenous Andean citizens remained colonized and were considered by the Spanish to belong to a separate Indian nation (Hudson 1992). Also at this time however, the indigenous population was experiencing an additional nationalistic surge where the pressure to fulfill civilian obligations to the new government as well as to local Andean communities led to a sense of multiple group memberships and thus multiple identity affiliations among many Peruvians (Garcia 2005; Hudson 1992).

Once Peru gained independence from Spain, the *mestizo* (children of mixed Spanish and indigenous descent) identity was conceived (Hudson 1992). The realities of *mestizaje* (the word given to the process of racial or ethnic mixing) challenged previous notions of identity however. During the post-colonial period, another way power was exerted was through the sexual exploitation of indigenous women who were considered by the Spanish to be rightful possessions gained from the conflict. Consequently, as the children of mixed descent were born with Spanish blood, they became embodied with the rights and privileges of the *criollo* and *mestizo* groups yet at the same time still faced the stigma of being indigenous. The introduction of Spanish culture and society into the daily lives of the indigenous Andean population during the colonial period therefore culminated in a survival strategy which was based on adaptation, resistance and exchange (Benavides 2014; Hudson 1992; Van den Berghe 1977). As the *mestizo*

population grew, so did their contributions to the social and economic development of the country (Benavides 2014; Hudson 1992; Van den Berghe 1977). With *mestizos* making up the majority of the working class, the indigenous Andeans were left behind as low paid laborers and peasants (Benavides 2014; Hudson 1992; Van den Berghe 1977). Their lessening tax contributions resulted in their further exclusion from the national political systems of power and control (Hudson 1992). Coexisting with the evolving national identities of the region thus became a matter of the indigenous population adapting and modifying Spanish cultural traits into an acceptable form compatible with their existing values (Hudson 1992). Equally, Spanish Peruvians adopted and adapted many indigenous Andean traits into their own culture, further contributing to the wide range of fluid multiethnic and multicultural identities still in existence today. As a result of the confusion that followed during the colonial and post-colonial time, ethnic mixing became condoned in hopes that it would dilute indigenous traits in favor of Spanish traits. The result, however, led to more confusion as indigenous discrimination continued, creating an environment where molding and redefining ethnic identity was still used as a coping mechanism (Migueléiz 2009). The stigma of having indigenous blood is thus still evident today and clearly visible in the ways indigenous Andeans are often regarded as second-class citizens with fewer opportunities and rights than non-indigenous Peruvians; the causes of which are described in the following section.

3.4 Historical Causes of Exclusion in the Andes

As described in the previous section, discrimination and exclusion experienced by indigenous Andean groups may often be attributed to *cultural* differences as opposed to *ethnic* differences between indigenous Andeans and other ethnic groups living in the nation. Canepa (2008, p.4) states that in Peru, “the tendency has been to assume that ‘difference’ precedes the cultural encounter, while on the contrary ‘difference’ is generated precisely in the context of cultural encounters such as colonialism....” Accordingly, Canepa’s (2008) argument that cultural differences are generated through historical cultural encounters is evident in the ongoing discrimination and racism still present in the nation. Peru’s ethnic composition for instance, is very mixed and built

from the "...hierarchal principals set down in colonial times that remain as powerful guidelines for intergroup and interpersonal behavior" (Hudson 1992, p.42). Popular ethnic identity labels still in use today, such as *criollo*, *mestizo*, or the more derogatory name for indigenous Andeans, "*cholo*" emerged in the wake of Peru's colonial past and signify the presence of historical processes in the development and classification of Peruvian and Andean ethnic identities. During the postcolonial period, when the process of *mestizaje* was at its peak, a parallel hierarchal system of race classification was also created by the Spanish elite (Cahill 1994). The caste system that was created divided people not only by cultural, ethnic and racial attributes, but also to the degree that they had acculturated to Spanish customs (Cahill 1994). Further, during this time, the Spanish elite also expected higher tax payments from the indigenous population (Cahill 1994). Thus as socio-economic status generally coincided with a person's socio-racial characteristics, indigenous exclusion based on ethnic classifications was continuously reinforced (Cahill 1994).

One of the most evident forms of indigenous exclusion is reflected by language tensions. Indigenous exclusion and language tensions in Peru also go as far back as the colonial period. Similar to many postcolonial settings, the Spanish conquest of the Inca Empire introduced a period of linguistic change (Hudson 1992). The Spaniards utilized cultural attributes such as the Spanish language and Catholicism as tools for domination (Benavides 2014; Hudson 1992). Although Spanish became the official administrative language of the Viceroyalty of Peru,²³ those in power, such as priests and missionaries, used Quechua to teach religion to the indigenous population as a way to acculturate them into Spanish society (D'Andrea 2007). Priests learned Quechua, produced dictionaries and translated the catholic bible (D'Andrea 2007; Van den Berghe 1977). Despite these efforts the majority of Quechua speakers learned Spanish as a means of resisting postcolonial oppression (Benavides 2014). For example, indigenous Andeans

²³ The Viceroyalty of Peru refers to the Spanish colonial administrative district that contained most of Spanish-ruled South America. The capital of the Viceroyalty in 1542 was Lima, Peru's current capital city (Encyclopaedia Britannica 2015).

who did not learn Spanish were considered less acculturated to the Spanish culture, and as a result had an even greater experience of unequal access to the rights and benefits of social citizenship than those who did learn Spanish. Indigenous Andeans were therefore seen as inferior and more susceptible to isolation and exclusion than their *mestizo* or *criollo* counterparts (D'Andrea 2007).

In Peru, the practice of learning the language of the oppressor as a defense mechanism continued past the postcolonial period. During the years following the civil war of the 1980s and 1990s that devastated the nation,²⁴ the Peruvian government and civil society organizations began implementing a series of reforms in support of the country's diverse multicultural population (D'Andrea 2007). One of the earlier reforms called for Quechua language instruction to be included alongside Spanish in the curriculum for indigenous school children. An anthropological study by Garcia (2005) describes the tensions resulting from these bilingual reforms. Despite their seemingly progressive nature, the majority of Quechua speaking parents in Peruvian Andean communities rejected them (D'Andrea 2007; Garcia 2005). Garcia explained that this may have been due to the nation's long history of discrimination and exclusion toward Peru's Quechua speakers resulting in indigenous Peruvians viewing Spanish as a more profitable language, that is, a language which would grant them greater opportunity and thus potentially greater rights to social citizenship.

Garcia's (2005) anthropological study, also in the Cusco region, describes the opposition toward bilingual education in Andean schools. One example she provides is a quote from an Andean teacher who argues that learning Quechua is not useful for children in the Andes:

Education is about teaching children...they must master Spanish, because everything in this country is a racist political game, and they must learn how to play, and how to win...teaching children in Spanish is not a denial of their

²⁴ The internal conflict in Peru which started in 1980 caused the deaths of nearly 70,000 people, mainly civilians. It was a conflict fought between the Shining Path (Peru's communist movement), the Peruvian government and the Tupac Amaru Revolutionary Movement (Gorriti 2012).

culture but rather the recognition that to get ahead in Peru, they need to speak and write in Spanish. (Garcia 2005, p.131)

As this teacher describes, many indigenous Andeans view the use of the Spanish language as a necessary means of coping with racism in the country as well as serving as a catalyst for social mobility. Disagreements over lingual preferences in the immediate postcolonial period as well as now indicate the ambiguity of the Quechua language. In Peru, as D'Andrea (2007, p.7) writes, "it is simultaneously the language of an oppressed minority and the legitimated symbol of former national glory with the Incas." The problem that arises is that while the advocates of Quechua preservation accept the cultural value of the indigenous language, there are still arguments that the same language preservation simultaneously reinforces marginalization of its speakers in wider Spanish speaking society (Benavides 2014; D'Andrea 2007; de la Cadena 2000; Garcia 2005). In addition to tensions over language, indigenous Andeans have had to cope with centuries of various other forms of exclusion, in particular, problems associated with being female and indigenous in a multi-ethnic patriarchal society as will be described in the following subsection.

3.4.1 Female and Indigenous: The "Double Whammy"

As a nation with largely patriarchal customs, gender inequality is a persistent problem, in particular among the indigenous population (Velasco 2008). Gender roles in the Andes typically follow a patrilineal family system and are characterized by distinctive gender ideologies and a strict division of labor. Accordingly, the ways in which divided gender roles might limit the rights of women can be seen in the way rural family life influences health-seeking behavior in rural communities. For example, an important aspect of the division of labor in rural households is the gender based division of space (Benavides 2014). Indigenous Andeans of both sexes generally lead demanding lives centered on animal husbandry and subsistence agriculture. Their day typically begins at dawn and consists of a number of household chores including tending to the animals and farming (Benavides 2014). Both women and men are responsible for these activities; however women have the added responsibility of tasks within the home such as

childcare, cooking, laundering and guinea pig rearing (Benavides 2014). Moser (1989, p.1801) attributes rural women's additional responsibilities to "the triple role of women". In writing about gender and development, she explains:

In most low-income households, "women's work" includes not only *reproductive* work (the childbearing and rearing responsibilities) required to guarantee the maintenance and reproduction of the labor force but also *productive* work, often as secondary income earners. In rural areas this usually takes the form of agricultural work...In addition, women are involved in *community managing* work undertaken at a local community settlement level...With the increasingly inadequate state provision of housing and basic services such as water and health, it is women who not only suffer most, but also who are forced to take responsibility for the allocation of limited resources to ensure the survival of their households. (Moser 1989, p.1801)

This triple role is also evident in Andean communities of Peru, where men's tasks mostly take place outside of the house in the fields, while the majority of women's tasks take place inside the house or in the community (Benavides 2014), which is seen to be an extension of the "domestic arena" of women (Moser 1989). The gender based division of space and labor can thus be interpreted to be associated with Andean women's reproductive responsibilities (e.g., childcare). Further, rural households have a patriarchal structure of authority which is also discernible in the gender specific responsibilities of the household. For example, Andean men traditionally hold the roles of main wage earner and decision-maker in rural households (Benavides 2014). Although many women engage in commercial activities in addition to household responsibilities, such as selling agricultural produce or making and selling handicrafts in the local village markets, the majority of indigenous Andean women living in rural communities are dependent on their male partners for household income. Women's general dependency on their male partners has a number of implications for gender based inequalities in the region which can influence health seeking behavior. In terms of accessing necessary reproductive health services such as family planning or pre and post natal care (as will be described in Section 3.5 of this chapter), women often have to rely on their partner's approval to seek care. A significant consequence of this is the lack of autonomy of women as decision-makers in the right to seek health services. This in turn

has the effect of potentially granting men a greater degree of authority over their female partner's bodies. As members of the indigenous population, indigenous women in Peru are already members of an excluded population. Indigenous women are thus doubly excluded and are continuously disempowered and relegated to second-class status within their own communities (Physicians for Human Rights 2007).

Perhaps the most notorious example of gender based inequality in the region is the forced sterilization crisis which took place in the 1990s²⁵ (Lopez 2014). The government led human rights violations against indigenous Peruvian women, which occurred during the Fujimori regime, saw more than 330,000 indigenous women sterilized without their consent between 1995 and 2000 (Barthélémy 2004). These acts occurred in the guise of a controversial “public health plan”, implemented in 1995 and backed by USAID and later UNFPA, designed to control the growing population of the country, particularly in areas of high poverty (Barthélémy 2004). The plan, which ultimately led to an international legal investigation, mainly targeted towards individuals living in areas where the Shining Path guerilla group was in conflict with the Peruvian government (BBC 2002). Further, during the investigation it was found that doctors were required to meet quotas in these areas and that Fujimori was aware and informed each month of the number of sterilizations carried out (Barthélémy 2004). Although Fujimori is now in prison for committing crimes against humanity, cases such as this show that indigenous women face even greater threats of exclusion and discrimination, and thus more limited access to social citizenship.

Gender inequality in Peru is thus inextricably linked to poverty and ethnic discrimination. As the majority of indigenous women have to relegate decision-making to the men in their families, men generally handle important health care decisions for the women. As a result, it can be argued that indigenous women have reduced agency over their own bodies. Even government health and other social programs aimed to provide

²⁵ One of the measures undertaken to decrease poverty levels by then President Fujimori, who is currently imprisoned for human rights abuses, was to forcibly sterilize indigenous women, often without their knowledge or consent (Lopez 2014).

assistance to women often reinforce gender stereotypes. For example, programs such as Juntos²⁶ typify women as caregivers rather than emphasizing gender equality and treating women as equal to men (Physicians for Human Rights 2007). Examples such as these highlight the deeply entrenched inequalities faced by the indigenous population, in particular indigenous Andean women. The following section thus provides an overview of the health system and some of the ways maternal health is negatively affected by health inequalities and indigenous exclusion in the Andean region.

3.5 Health System Overview and Andean Maternal Health

The Peruvian health system is currently made up of multiple decentralized institutions, both public and private. The Ministry of Health (MINSA) provides coverage for the majority of the population (approximately 60%) (Global Health Workforce Alliance 2015). EsSalud, which provides care for the formally employed covers approximately 30% of the population, and the military health system, the national police force and private and non-profit organizations cover the remaining 10% of the population (Global Health Workforce Alliance 2015). Although health care has been decentralized since its collapse and subsequent restructuring following the civil war of the 1980s and 1990s,²⁷ health care services coordinated by MINSA are carried out vertically and are unevenly distributed (Altobelli 2008). Hospitals, which carry out specialized care, are at the top (6% of the establishments), and are usually located in urban areas. Below hospitals are health centers (25% of the establishments), also generally located in urban areas, followed by health posts at the bottom which deliver primary care (65% of the establishments) (Figure 9) (Physicians for Human Rights 2007).

²⁶ Juntos is a conditional cash transfer program in Peru implemented in 2005 and aimed to alleviate poverty for those who experienced the violence of the 80s and 90s (Fernandez and Saldarriaga 2014).

²⁷ Decentralization of the health system following the civil war revolved around the assumption that regional governments would be better equipped with local knowledge to meet the needs of communities under their jurisdiction, however a history of high turnover of regional directors has hindered these attempts (Davenport 2007).

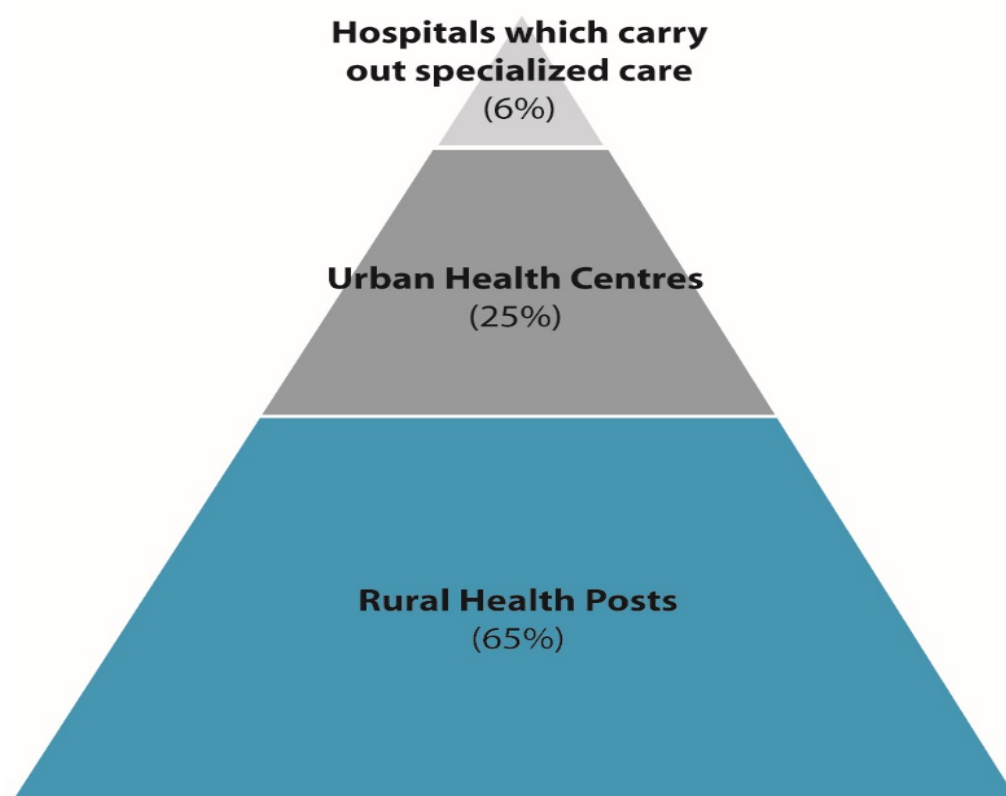


Figure 9: Structure of health services

Primary care is thus carried out at the lowest level of the health system, however many studies have shown that structural problems plague the efficiency of these facilities (Altobelli 2008; Amnesty International 2009a; Amnesty International 2009b). According to the 2007 National Census of Peru, 59.1% of indigenous communities in Peru did not have a health facility. Of the remaining indigenous communities, 45.4% were only equipped with a basic first aid post, 42.3% had a health post and only 10.9% had access to a health center (Amnesty International 2009a; Amnesty International 2009b; Instituto Nacional de Estadística e Informática 2008).²⁸ A report by Physicians for Human Rights (2007) further states that the 92 national blood banks are also poorly distributed throughout the country.

²⁸ The remaining 1.4% are not accounted for in the literature (Amnesty International 2009b).

Quality control at all health facilities including the blood banks has been recognized as a persistent problem throughout the country (Physicians for Human Rights 2007). Some reasons identified for this include the low staff recruitment and retention rates which result from a lack of regulation in the employment status of public health providers (Physicians for Human Rights 2007). As a result, poor staff incentives and a lack of job security contributing to staffing shortages are a significant problem in rural Andean communities (Amnesty International 2009a).

In 2009, figures from the Peruvian government placed Peru's MMR at 185 maternal deaths per 100,000 live births, while the United Nations put the number at 240 maternal deaths per 100,000 live births (Amnesty International 2009b). In consideration of the 2015 MDG deadline, Peru's MMR has significantly declined over the past decade. As of 2013, Peru's Health Ministry has said that the rate of women who die during childbirth has decreased to an MMR of 93 (del Carpio 2013; s.n. 2013). Despite such a decline, Peru is still unlikely to meet the 5th MDG goal of 66 maternal deaths per 100,000 live births, arguably due to the significant lack of attention the SDH have played in the development of the MDGs (World Bank 2011).

According to the Ministry of Peru's national sexual and reproductive health strategy, further lowering of MMR rates requires inputs from other sectors such as communication, transport, and education, among others (Ministerio de Salud Peru 2004). Further, in accordance with global maternal health trends, ensuring women receive sufficient prenatal care and also give birth in the presence of skilled birth attendants are considered some of Peru's main determinants of experiencing a healthy pregnancy, childbirth and postpartum (UNICEF Devpro Resource Centre 2009).

According to World Bank (2012) data, 96% of women in Peru attend at least one prenatal visit during pregnancy. Despite this high national percentage, many women in Andean communities do not always attend prenatal visits or give birth in the presence of a skilled birth attendant (Amnesty International 2009a; Physicians for Human Rights 2007). This can be detrimental to the maternal and neonatal health in that Andean women who receive minimal antenatal care and give birth at home face a greater risk of

death because they cannot reach health facilities in time to treat emergency situations should they arise (Amnesty International 2009a; Amnesty International 2009b). This is reflective of the severity of distal causes of death affecting the indigenous population which are a result of several individual, institutional and structural barriers to formal maternal health services in the region as will be described below.

3.5.1 Individual, Institutional and Structural Barriers to Maternal Health Care

The nation's continuously high maternal mortality rates appear to reflect at least three levels of persistent ethnic and gender based discrimination. At the *individual level*, evidence of extensive discriminatory attitudes among health professionals towards indigenous Peruvians which could potentially lead to reluctance to use formal health facilities has been documented throughout the country (Physicians for Human Rights 2007). The report by Physicians for Human Rights (2007) for example, describes how maternal health providers in the rural Andean regions of Huancavelica and Puno used the terms “backwards” or “ignorant” when referring to the indigenous population. The report also documented “...examples of outright coercion targeted at indigenous populations to give birth in health establishments, such as the use of police and threats of incarceration...” (2007, p.10). Further, women in rural areas are not always empowered to make informed decisions regarding health seeking behavior. Accordingly, gender inequalities such as those discussed in Section 3.4.1 highlight how rural women often have to relegate agency over their own bodies to men or those holding positions of power in the institutions (e.g., police).

At the *institutional level*, exclusion is evident by the types and quality of services which are offered. The language and culture of the health system (as described in Chapter 1, Section 1.2 of this study) itself differs from the needs of the indigenous population. For instance, despite the majority of indigenous Andeans being solely Quechua speakers, health services are generally carried out in Spanish (Bristol 2009). Prescriptions and medication information are likewise provided in Spanish rather than Quechua. The lack of health personnel who speak Quechua within the health institution constitutes a clear

form of institutionalized discrimination. The possible implications of this are that health seekers in need of care, whether life-saving or general may end up leaving the health center with limited to no understanding of the health professional's advice (Physicians for Human Rights 2007). An additional institutional form of exclusion is the lack of culturally sensitive health facilities. The Andean belief system regarding health and illness is based around religious and magical elements. Indigenous Andeans, for instance, traditionally believe that illness is generally beyond individual control. Diseases and afflictions are instead often believed to be caused by external forces such as possessing spirits or imbalances in nature (Garcia 2009). Traditional remedies for complications which might occur during pregnancy, childbirth or postpartum thus typically consist of natural ingredients and shamanic rituals aimed to rid the body of evil and restore the balance of the natural world (Garcia 2009). Further, traditional indigenous Andean beliefs generally associate pain with illness, implying that if pain is present, then there is illness, and alternatively a lack of pain indicates a lack of illness (Garcia 2009). These beliefs differ from biomedical approaches which aim to treat complications with pharmaceuticals or other medical interventions. Biomedical approaches to child birth with its emphasis on facility based vertical birthing, particularly contrasts with traditional preferences. The traditional birthing preferences of indigenous Andean women, for instance, include opting for home deliveries over facility based care. Many indigenous rural women prefer to give birth in a vertical squatting position in a darkened room, assisted by a rope hanging from the ceiling and the presence of a traditional birth attendant and family members (Amnesty International 2009a; Amnesty International 2009b; Bristol 2009). Pregnant women are also encouraged to drink herbal teas and soups and chew coca leaves during labor. This can be attributed to the common Andean belief that associates illness to an imbalance of "hot" and "cold" elements of the body or environment (Garcia 2009). A "hot" illness for example is due to too much heat in the body and needs to be treated with a "cold" remedy. Conversely, a cold illness would be treated with a "hot" remedy. Hot and cold elements typically vary by family or region and affect the body in different ways (Garcia

2009). The following passage by indigenous rights activist Hilaria Supa Huaman describes traditional birthing in the Andes:

In the countryside, when a baby is about to be born, the woman kneels over a sheepskin. Her partner rubs her waist, gives her herbal infusions, and makes her chew coca leaves. The midwife feels the mother's pulse and knows if the baby's position is right for it to be born. If the baby is in the wrong position...they lay the woman down on a tarp and shake her in a special manner, in order to turn the baby and ease her labour...As soon as the baby is born the mother is tied at the navel with a *chumpi*...really tight because after childbirth the mother's womb starts to move, looking for the child that is already out. If this is not done, the womb can move up to the heart, making breathing difficult and causing the mother's death... (Supa Huaman 2008, p.24-25)

Regardless of whether this style of birth is considered safe or not by the biomedical community, it is a style of birth that is clearly in contrast to the cold sterile environment of western style health facilities, such as those offered in Peru. The absence of ensuring systemic provision of culturally adapted birth facilities thus poses another barrier to maternal health care specific to indigenous communities (Amnesty International 2009b).

At the *structural level*, structural inequalities or structural barriers to care against the indigenous population affect the way health services are provided and result in further discrimination of indigenous Andeans needing care. Structural violence, as described in Section 2.2 of this thesis is evident in Peru in that far fewer resources are allocated to rural communities with high indigenous populations. Physicians for Human Rights describe the problems with resource allocation to be a result of spending inequities between urban and rural areas, which then lead to poorer quality and availability of care for the rural indigenous population (Physicians for Human Rights 2007). Undoubtedly, one of the most significant barriers to care for indigenous women has been the indirect costs associated with visiting the health facilities. This can include, for example, the costs of transportation to get to the health facilities or time lost from work during travel (Partners in Health 2011).

3.6 Government Level Interventions to Improve Maternal Health

The Peruvian government has adopted many programs in alignment with international and national initiatives to improve maternal health. For instance, Peru has shown commitment to the Safe Motherhood Initiative launched in Nairobi in 1987, the International Conference on Development and Population held in Cairo in 1994, the World Conference on Women held in Beijing in 1995, and the United Nations Millennium Declaration of 2000 in which the MDGs were developed (Migueluez 2009). At the national level, Peru developed the *Acuerdo Nacional* (National Consensus) in 2002, which aimed to provide universal access to health care and reduce discrimination toward the indigenous population (Gobierno del Peru 2002). The government strategies resulting from these commitments were summarized in the 2009 document known as the “Technical Bulletin: National Strategic Plan for the Reduction of Maternal and Perinatal Mortality 2009-2015” (Ministerio de Salud Peru 2009b). Prior to this document, the majority of Peru’s maternal mortality reduction efforts were covered under wider sexual and reproductive health initiatives and were not specific to maternal health. Consequently, this document was the first time maternal mortality reduction was listed as a priority (Migueluez 2009). Two key issues were identified in the analysis of Peru’s national and international commitments to reduce maternal mortality. These were: 1) maternal health services were found to be significantly underutilized and 2) if services were utilized, the majority of target populations, such as rural indigenous women, reported substandard care (Migueluez 2009). Similar to some of the maternal barriers already listed in this thesis, the surveys conducted for this document listed the main reasons for underuse of services among the target population as: cost, fear of mistreatment, long waiting times, shame and embarrassment or fear of being stigmatized over being pregnant, and distance from health facilities (Ministerio de Salud Peru 2009b). Clearly, all of these reasons, aside from distance can be linked to poor quality of care resulting from the SDH and further contribute to indigenous exclusion from health services.

Since 1998, the Peruvian Ministry of Health, in conjunction with UNICEF Peru has implemented a fourfold strategy to address the geographic, cultural and economic barriers limiting access to facility based maternal health services for rural indigenous women (UNICEF Devpro Resource Centre 2009). The four key strategies, which will be examined in the following subsections, are:

1. The establishment of maternal waiting homes (MWHs);
2. Establishing the availability of health insurance to cover the costs of maternal health services for families in poverty; and
3. Adapting maternal health services to accommodate traditional childbirth practices; and
4. Prioritizing pregnancy and maternal health through community support (discussed in section 3.7).

3.6.1 Maternal Waiting Homes

Maternal waiting homes (MWH), or *mamawasis* as they are referred to in Peru, were established to meet one of the four key strategies implemented by the Ministry of Health and UNICEF Peru as described above. Many LMICs worldwide have introduced MWHs as a way to encourage the use of facility based care during pregnancy (Figa'-Talamanca 1996). In Peru, the challenge is to ensure that pregnant women have access to skilled birth attendance and facility based care without disregarding traditional practices (UNICEF Devpro Resource Centre 2009). Towards this end, an estimated 400 *mamawasis* have been constructed on hospital and health center grounds throughout rural areas of Peru (UNICEF Devpro Resource Centre 2009). Expectant mothers and their family members can stay in these waiting homes, which are built to resemble a typical rural family home, for several weeks or months up until they deliver (UNICEF 2009). The main benefit of *mamawasis* is that they encourage rural women to give birth in facilities rather than at home (UNICEF 2009). Their location on hospital grounds or in nearby rented buildings ensures that women are in a close proximity to a health center when labor starts. Emergency obstetric care would thus be readily accessible should

complications arise. After the birth, women and their newborns can also return to the *mamawasi* so that they can be monitored (UNICEF 2009). To date, various studies argue that *mamawasis* have contributed to the rise in institutional deliveries throughout rural areas of Peru (Callister 2009; Figa'-Talamanca 1996; Fraser; UNICEF Devpro Resource Centre 2009). In Huancarani district for example, which is located in the Andean province of Paucartambo in the Cusco region, almost three out of every four pregnant women give birth in health facilities while prior to the implementation of *mamawasis*, the estimate was one in four (UNICEF Devpro Resource Centre 2009).

Despite such an increase in institutional deliveries, there is limited research as to whether or to what extent *mamawasis* actually improve the quality or accessibility of facility based maternal health services. Moreover, some reports indicate that the logistics of actually using a *mamawasi* often deter women from using them (Satti et al. 2013; Wild et al. 2012). A report by the World Health Organization (1996), points out that it is not just geographical distance which deters some women from giving birth in health facilities. Factors such as lack of childcare or needing to stay home to tend to the fields and animals often make leaving the home for an extended period of time inconceivable for rural women (World Health Organization 1996). This indicates that *mamawasis* may not be a feasible solution for most indigenous women despite the potential benefits of being close to health facilities.

3.6.2 Health Insurance

Peru's comprehensive health insurance program, *Seguro Integral de Salud* (SIS) was developed from an initial insurance program which specifically aimed to address economic barriers for rural women and their newborns (Grajeda Ancca et al. 2001). This insurance program covers the cost of antenatal, intrapartum and post-partum care for rural families who cannot otherwise afford it (UNICEF Devpro Resource Centre 2009; UNICEF 2009). Mandated by the Ministry of Health, 94% of SIS is funded by the general budget and the remaining 6% comes from donations and contributions from international aid agencies and other institutions (Alcalde-Rabanal et al. 2011). Coverage

is granted to individuals and their families based on economic level and priority is given to vulnerable populations, such as indigenous Andeans who are living in poverty or extreme poverty (Alcalde-Rabanal et al. 2011).

3.6.3 Cultural Adaptation of Health Services

In 2005, the “Technical Standard for Vertical Delivery with Intercultural Adaptation” was approved by Peru’s Ministry of Health (Ministerio de Salud Peru 2005). This policy was developed to ensure that rural indigenous women’s cultural preferences would be accommodated during childbirth. Offering vertical delivery in health facilities was thus adopted as a national strategy in order to promote a multicultural and gender sensitive approach (Velasco 2008). According to this policy, all health personnel should be technically trained to perform obstetric procedures for women opting to give birth in non-horizontal positions (e.g., squatting kneeling, seated or holding on to a rope) (Velasco 2008). The policy also states that patients and their relatives should be welcomed and the procedures enacted on the women during labor should be explained in a simple way while also encouraging them to be able to choose the position in which they would like to give birth (Velasco 2008). The presence of such potentially patronizing statements in a national policy highlights the extent to which the barriers indigenous women face derive from the institution of the health system itself.

Nevertheless, on the surface, the intercultural birthing policy implemented in 2005, along with maternal waiting homes and SIS do seem to have a positive influence on improving women’s access to maternal health services, however this is deterred by weaknesses in their implementation. Maternal mortality rates in Peru are still unnecessarily high with many indigenous women continuously opting to avoid health facilities all together. Approaches that aim to empower the indigenous population to gain control over their health rights have therefore also been emphasized in government strategies as will be explained in the following section.

3.7 Community Level Approaches to Reducing Maternal Health Barriers

Community participation is a critical component to the functioning of each of the above key strategies and is a fundamental principle of PHC (UNICEF Devpro Resource Centre 2009). While intended to strengthen the health system through increasing access to facility based care, maternal health interventions should equally rely on community support to link the community to the health system. Peru has been known to be “...among the few countries in the world that has a government health program with legalized, regulated, and institutionalized community participation” (Altobelli 2008, p.1). Even prior to the development of the government’s fourfold strategy discussed above, the Shared Administration Program was implemented in 1994 to give the community shared responsibility over the Ministry of Health’s PHC system (Altobelli 2008). A program like this is rare in Latin America, however it was initiated in the wake of the collapse of the health sector following the decade long civil war of the 1980s and 1990s (Altobelli 2008). Under this program, Local Committees for Health Administration (CLAS), accountable to the Ministry of Health, are responsible for meeting local health needs and conducting surveys to assess potential unmet needs (Iwami and Petchey 2002). The program is legally mandated by a contract signed between a region’s CLAS and each region’s decentralized Department of Health (Altobelli 2008). While each region’s CLAS has responsibility over administration of health services, the Ministry of Health takes responsibility over the financial implementation of the health program (Altobelli 2008). Although CLAS is an example of a government strategy to manage community level PHC services, scholars such as Altobelli (2008) argue that community participation resulting in these programs has been essential to reducing health inequalities. Accordingly, community participation can be a valuable empowerment strategy that effectively addresses some social barriers to health services, in particular in regions of ethnic exclusion and institutionalized discrimination (Altobelli 2008; Taylor-Ide and Taylor 2002; Wallerstein 2006; World Bank 2001).

Community participation and support can thus be important mechanisms for promoting the use of facility based care and improving maternal health overall. For example, in reference to MWHs in Cuba and Columbia, Figa'-Talamanca (1996, p.1386) states that "...before planning a MWH, it is necessary to develop a network of health workers with the technical capability and the credibility and respect of the community, whose role would be to identify and refer pregnant women for admission to the MWH." Further, she argues that support from the community is important to establishing credibility because otherwise women and their families might be reluctant to leave home to go to the MWH. Figa'-Talamanca thus emphasizes that community support encourages women to make use of some of the facility based interventions such as MWHs.

Community support cannot always be fostered independent of the government however. Dr. Miguel Gutierrez, the director general of Pathfinder International and president of the Peruvian OB-GYN society has emphasized the importance of government support for mobilizing the community. Referring to the delays in reaching and receiving maternal health care (as described in Section 2.4 of the previous chapter), he says: "We have always talked about the three delays... The first one blames the woman for not recognizing her danger signals. The second delay blames someone, usually her husband, for not making the decision to go to the hospital. The third one blames the hospital personnel for not knowing what to do" (Davenport 2007, p.6). Gutierrez suggests that adequate response from the government affects all of the other delays and that transforming the way health systems are developed and implemented requires a multi-sectorial approach which views "...the health system as a social institution, deeply connected to the communities it serves" (Davenport 2007, p.6). This therefore coincides with the importance of the critical fourth delay described in Section 2.4 of the previous chapter, that is, the delay in the community accountability of maternal health services.

3.7.1 Community Health Workers: The History and Development of Peru's CHWs

One important community based approach to improving health in Peru has been through the implementation of CHW programs. The development of CHWs in Peru can be

attributed to the work conducted in the 1930's by the *Movimiento Rijchary* (Rijchary Movement). The Rijchary Movement was a social reform movement, formed in the city of Puno, which aimed to develop educational, literary and artistic activities. Health promotion was also a large part of this movement (Hazen 1981). Its director, a doctor named Manuel Nuñez Butron led the training of the first volunteer health promoters (Ministerio de Salud Peru n.d.). In the year following Alma-Ata, Peru's Ministry of Health implemented a formal health promoter program, naming the volunteer health promoters as valuable players in achieving "health for all" (Ministerio de Salud Peru 2007). Since then, the Ministry of Health has continued to develop interventions aimed to enhance community health promotion activities. One of these interventions was the establishment of *Agentes Comunitarios de Salud* (ACS) translated as, Community Health Agents (Ministerio de Salud Peru n.d.).

The ACS, or CHWs²⁹ as they are also commonly referred, can be both men and women and are selected by the communities they serve. As a report by WHO and UNICEF on the management of sick children by CHWs describes, many of the CHWS selected have previously participated in other community based health promotion activities (Gilroy and Winch 2006). Peru's CHWs are usually taught by Ministry of Health personnel. Accordingly, each public health center is responsible for training the CHWs who work in their corresponding jurisdictions (Ministerio de Salud Peru 2007). The activities they perform are generally based around health promotion and illness prevention. They are also responsible for mapping out and monitoring each of the households, as shown in Table 2, in order to report back to the health center (Gilroy and Winch 2006). The Ministry of Health's (2007) Technical Document for Working with Community Health Workers lists their general tasks as follows:

²⁹ In Peru, CHWs are referred to by a variety of names including ACS, CHWs and Health Promoters. For reasons of practicality and consistency, this thesis uses the term CHW to refer to all community health workers in Peru.

Individual Level	Family Level	Community Level
<p>Care for their own health and their family's health.</p> <p>Take children for periodic check-ups.</p> <p>Provide guidance to family members about health care.</p> <p>Act as a role model in the community for leading a healthy lifestyle.</p> <p>Promote personal hygiene habits and sanitation: hand washing, tooth brushing, disposal of trash and waste.</p> <p>Maintain records of basic health information at the individual level.</p>	<p>Monitoring children's height and weight.</p> <p>Making home visits.</p> <p>Monitoring personal and housing hygiene.</p> <p>Mapping out and Monitoring high risk families.</p> <p>Locate and refer children to the health posts for periodic check-ups.</p> <p>Promote healthy pregnancy.</p> <p>Ensure pregnant women are getting proper nutrition.</p> <p>Lactation support and promotion.</p> <p>Promote the healthy habits among families.</p> <p>Maintain records of basic health information of</p>	<p>Participate in educational communication activities in the community.</p> <p>Educate the community in proper nutrition.</p> <p>Educate the community in traffic and road safety.</p> <p>Organize neighborhood watch activities.</p> <p>Participate in the community referral system.</p> <p>Motivate the community to participate in physical activities to ensure current and future health.</p> <p>Motivate the community to avoid the consumption of tobacco, alcohol and drugs.</p> <p>Support activities for learning health habits and values within the community.</p>

	community members.	
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Table 2: List of CHW tasks

Peru's Ministry of Health has developed several documents and technical papers providing information about the expected role and responsibilities of CHWs. The *Manual del Agente Comunitario de Salud* (The Manual for Community Health Agents) originally published in 2001 and updated in 2007 and 2009, was written with the specific intention to prevent the deaths of mothers, infants and children (Ministerio de Salud Peru 2009a). The manual states that the responsibility of the CHW is to guide expectant mothers and their partners through promoting healthy behaviors. In terms of maternal health, the CHW is thus expected to aid the mother and her partner in preventing complications through the following activities:

- Ensure that the mother attends all of her pre-natal and post-natal checkups in a health facility in order to prevent or treat any possible health complications for her or her baby.
- Maintain healthy eating habits and proper hygiene to prevent sickness.
- Ensure that the birth takes place in a health facility with the presence of a skilled birth attendant.
- Ensure the mother breastfeeds her baby for at least 6 months up to 2 years.
- Ensure that the mother and her partner are aware that they should wait until their child is at least 3 years old prior to becoming pregnant again.

The most distinctive features of Peru's CHWs as can be seen by the activities they are expected to participate in are the emphasis on health promotion and illness prevention. Through promoting good nutrition, breastfeeding and birth spacing, CHWs can serve as a valuable community level provider of information. However, despite the government's incorporation of CHW programs into health improvement strategies, there is very little research about CHWs in Peru. This significant gap in important information perhaps highlights why community level interventions, though generally positive, have not

succeeded in leading Peru to meet the targeted MDG goals. Accordingly, “in Peru”, as Brown et al. state (2006, p.478), “aside from a few reports...there is no up-to-date information on the involvement and participation of community health workers in primary health care policies, projects and interventions or profiles of these actors. Yet they are directly involved in the development of those interventions at community level.” Recognizing the vast potential CHWs could have for improving access to maternal health services in indigenous communities and finding limited literature on whether or not they can in fact be advantageous to helping community members overcome ethnic exclusion and institutional barriers to care has thus led to the development of this study in order to attempt to fill some of these gaps.

3.8 Conclusion

This chapter has provided an overview of the development of indigenous exclusion in Andean communities and how this has influenced the state of maternal health services in rural indigenous communities today. It has been shown that poverty and exclusion are inextricably linked and highly present in indigenous communities. As such, this chapter has examined the historical development of the nation’s social structure and potential reasons for exclusion. In so doing, issues pertaining to race, ethnicity and culture were discussed in order to explain some of the possible social and structural reasons for the unnecessarily high maternal mortality rates in these communities. This chapter has explained how maternal health services are provided as well as some of the social and structural barriers contributing to high death rates in the country. With such challenges acknowledged by government agencies, improving maternal health services has been a top priority. Some of the approaches used have aimed to improve maternal health through community level interventions. This chapter has provided a discussion of these approaches and has examined the history and development of CHW programs in the region. Accordingly, this chapter has highlighted some of the tasks expected of CHWs in providing basic maternal health services to their fellow community members. Given the potential for CHWs to help decrease social exclusion from maternal health services and the significant lack of literature surrounding the role of CHWs in Peru, this study was

developed to examine how CHW programs are perceived by potential health seekers and providers of care (including the CHWs themselves). This study thereby seeks to identify whether CHWs can be a useful means to enhance the availability, acceptability and quality of maternal health services which are otherwise hindered by the SDH in the Andean region. The following chapter hence describes the research design and methodology used to conduct this study.

Chapter 4: Research Design and Methodology

4.1 Introduction

While the previous chapters have discussed some of the important concepts from the literature explaining the links between indigenous exclusion and maternal health in rural Andean communities, this chapter presents the research design and methodology used to carry out this study. It begins with a discussion of the philosophical assumptions underpinning the development and implementation of the study (4.2), leading into a review of the methodology employed (4.3) and the rationale behind choosing these methodological approaches over others. This study, as will be specified throughout this chapter, is qualitative and has been designed around an approach rooted in interpretivism and symbolic interactionism. As such, the role of the researcher in interpretivist studies is discussed in Section 4.4. This section and its following subsections explain researcher positionality and reflexivity in order to emphasize this study's view that the researcher is an active participant in the interpretation of the social phenomena in question. The remainder of the chapter details the specific methods utilized to collect, manage and analyze the data. Accordingly, following a brief discussion of fieldwork preparation (4.5), the methods used for sampling and recruitment of participants are explained (4.7), which also include a description of eligibility criteria for potential participants. Section 4.8 details how the data was collected and sections 4.9 and 4.10 discuss some of the study limitations and ethical considerations respectively. The penultimate section of this chapter (4.11) discusses the data analysis techniques used. Section 4.12 concludes this chapter.

4.2 Philosophical Assumptions Underpinning this Research

The methodological choices adopted in this investigation have been guided by an interpretivist paradigm and a symbolic interactionist theoretical perspective. This study thus operates under a philosophical stance which emphasizes the interpretations of social interactions as a means to develop an understanding of the relationships between the micro-level factors of exclusion (eg., the experiences of indigenous Andean community

members seeking maternal health services), with the greater macro-level issues that give rise to structural inequalities and institutionalized discrimination in Andean communities. Accordingly, to discern the ways in which ethnic and social relations are formed and thereby appropriated into the lived experiences of Andean peoples, a methodological framework based on a social constructionist epistemology is applied. The following subsections thereby describe the central concepts associated with the philosophical assumptions driving this study, beginning with a discussion of social constructionism and interpretivism as they relate to symbolic interactionism. Issues pertaining to symbolic interactionism and systems of power are then explained including a discussion of the ways in which this study utilizes a micro-level approach to conceptualize macro-level social structures relevant to the Peruvian Andean context.

4.2.1 Social Constructionist Epistemology

Epistemology, according to Crotty (1998, p.3) refers to “the theory of knowledge embedded in the theoretical perspective and thereby in the methodology” [of a study]. In short, epistemology, is concerned with the nature of knowledge, or “...*how we know what we know*” (Crotty 1998, p.8). As such, a researcher’s epistemological position guides the development of the research design and methodological choices. Social constructionism, correspondingly is the epistemological stance that all knowledge and meaning is constructed through human interaction with the social world (Crotty 1998). In considering the varying social and cultural factors leading to experiences of exclusion between members of Peruvian society, this perspective was adopted as a way of understanding how the values, attitudes and belief systems of the participants (and researcher) are constructed and in turn represented in their interactions with one another.

Andrews (2012) argues that under a social constructionist epistemology, society is regarded as potentially existing within both an objective and a subjective reality. Under this perspective, a society can be viewed as existing on a continuum between realism and relativism where one objective reality exists on one end and multiple constructed realities exist at the other (Andrews 2012). Within this view, objects in the world are

granted meaning only through the engagement of human consciousness, that is through the associations individuals or members of a social group grant to them. This is not simply to say that objects, and therefore reality would not exist without the emergence of the human mind. For writers such as Hammersley (1992), the existence of an external reality is quite possible; however without conscious perception of such a reality, it is located out of human reach. The notion that an object is only given meaning through a socially constructed interpretation can thus denote a mutually shared understanding between those who adhere to this meaning. The shared associations humans ascribe to objects hence imply the presence of a possible tacit objective reality while at the same time allowing for the existence of multiple realities (Crotty 1998). This middle ground position, or *subtle realism*, as Hammersley (1992) refers to it, is consistent with the idea that "...reality is socially defined but this reality refers to the subjective experience of everyday life, [or] how the world is understood, rather than to the objective reality of the natural world" (Andrews 2012, p.2).

Social constructionism, in this sense, is concerned with the ways in which the social world is interpreted and thus represented through social constructions of reality, as opposed to ontological claims about the causal forces intrinsic to the natural world (Andrews 2012). Challenges to this view, particularly from those of a more anti-positivistic or interpretive bearing where the existence of any form of an objective reality is denied, take issue with the implied division between social and natural realities. Philosophers such as Windelband and Rickert for instance argue against any sort of real distinction between a natural and social reality, however they do accept that there are different purposes towards the study of each, separated by a logical distinction posited by the human mind (Jalbert 1988). From this perspective, the social and the natural worlds should not be considered to exist as separate entities, but instead as belonging to one human world which is only meaningful through socially constructed interpretations of both social and natural phenomena (Crotty 1998).

Taking such ontological challenges into consideration, this study maintains a social constructionist epistemological stance. In doing so, and in keeping with a perception of

society as situated on a continuum between realism and relativism, the methodological approaches used to guide this investigation lean more towards a relativist understanding of the social world. Relativism, as defined by Swoyer (2010, p.1) refers to a “family of views whose common theme is that some central aspect of experience, thought evaluation, or even reality is somehow relative to something else”. As such, it assumes that society is viewed through relative constructions of meaning. Opponents of the relativist label are often quick to reject approaches based on such foundations because they can imply an “anything goes” attitude toward societal understandings (Slife and Richardson 2011). Similar to the challenges associated with the realist versus relativist dichotomy characteristic of social constructionism, the attitude that everything is relative may lead some critics to assume relativistic claims to be implausible or even trivial (Swoyer 2010). This position thus begs the question that if all truth is relative, then how can it be credible or valid? It is at this point where it becomes important to distinguish between *constructionism* and *constructivism* and how these concepts relate to the verifiability of relativist interpretations and constructions of social meaning. Often used interchangeably, the two terms both refer to constructed interpretations of the social world. However, authors such as Andrews (2012), Crotty (1998) and Charmaz (2006) argue that *constructivism* focuses exclusively on the cognitive process of the individual mind, while *constructionism* refers to the collective experience of social groups (Andrews 2012; Charmaz 2006; Crotty 1998). By making this distinction, it not only becomes possible to come to terms with the ontological challenges outlined above, but also with the realist-relativist argument of claims to legitimacy. In these terms, scientific knowledge specific to the natural world can be cognitively interpreted through the constructivist thought process of the individual mind, while the social world is experienced collectively through a constructionist lens. “The natural scientist” as Crotty (1998, p.58) states, thus “constructs knowledge of the natural world by engaging with it in a scientific mode, but the social world is already interpreted ‘before the social scientist arrives’”.

This positioning accordingly suggests that each view of the world can be valid as long as the mode and purpose of inquiry is made explicit. The constructivist understanding of the world, for instance, places value on the individual experience of interpretations of meaning, while the constructionist view emphasizes the shared meanings generated from these experiences as they are created or transmitted through cultural conventions such as language or other social mechanisms. In this context, knowledge is constructed through human interaction with the world, whether social or natural. However the way it is constructed, and therefore the meaning granted to it is dependent on the attitudes, values and belief systems characteristic of a social group and in turn reflected in the varying relationships of its group members (Andrews 2012; Charmaz 2006; Crotty 1998).

The social constructionist epistemology therefore encompasses the individual experiences inherent in constructivist understandings of social processes as well as the social and cultural factors which influence social interaction. As such, the notion of the researcher as an active participant in the co-construction of social interpretations of reality is brought to the fore. The following subsection thus discusses this concept in the context of describing interpretivism and symbolic interactionism as the underlying philosophical perspectives driving the methodology of this study.

4.2.2 Interpretivism and Symbolic Interactionism

Originating in part from the writings of German sociologist Max Weber, the interpretivist paradigm is a belief system popular in the social sciences which “...*looks for culturally derived and historically situated interpretations of the social-life world*” (Crotty 1998, p.67). Closely related to constructivism (given its emphasis on cognition), interpretivism as understood from the sociological and anthropological traditions, aims to gain an emic understanding of the life world, or lived reality of social actors. It is an approach that strives to make sense of “...the complex world of lived experience from the point of view of those who live it” (Schwandt 1994, p.118). Developed as a critique of positivism and commonly linked to Weber’s influential *Verstehen* (understanding) philosophy, interpretivism, thus purports to understand “...the meanings and

interpretations, [and] the motives and intentions, that people use in their everyday lives and that direct their behaviour” (Blaikie 2000, p.115). Interpretive positions accordingly assume socially constructed and fluid realities where there are multiple, and equally valid claims to knowledge (Cohen and Crabtree 2006). The role of the interpretive social scientist is thus to understand and describe the perspectives of the social actors and the ways in which their varying beliefs and practices associated with their specific social and cultural settings are negotiated and articulated into their lived experiences and interactions with others (Blaikie 2000).

With attention focused on the understanding of social processes, the *Verstehen* approach implies a contrast between what is needed to comprehend the human and social world and that which is needed to explain (*Erklären*) the natural world. Where the latter is focused on analyzing the causal forces inherent in the natural sciences, the human and social world is instead reliant on understandings based on socially constructed interpretations of reality (Crotty 1998). Similar to the arguments already made above in the context of social constructionist and constructivist modes of thought, it becomes apparent that some key elements of interpretive inquiry are human consciousness and correspondingly human action. Here, the importance of agency is highlighted. With emphasis thus placed on the meaning people ascribe to actions, the individual, as Parsons (1978, p.111) describes, consequently becomes viewed as an active and “conscious agent” in the development of social processes:

The actor is a conscious agent continuously mindful of and responsible for the active application of normative codes in the interpretation of social reality. In this view society is not an unfolding of preestablished behavior patterns in (an assumed) highly stable environment of others and material objects but the creative production of interacting and interdependent agents who are skillful at interpretively understanding and communicating the sense of their own social worlds...these approaches point to the importance of interpretation...[of] the particular reality under study.

Parsons’ (1978) emphasis on agency, as reflected in the above passage, not only places the individual as continuously enacting the everyday norms and practices of their dynamic social environments, but also as consciously producing interpretations of their

social worlds through interactions with others. The focus on human agency and social interaction thus leads into the role of symbolic interactionism and the ways in which it has been utilized to guide the methodological choices of this study.

Sharing common philosophical underpinnings with the interpretivist paradigm, symbolic interactionism goes further to specifically focus on the *meanings* which are *created and maintained* through *social interaction* (Crotty 1998). Stemming from the American pragmatist tradition, where truth is understood through a pragmatic rendering of observable consequences, symbolic interactionism views “society as an emergent process continuously produced by human beings” (Shalin 1991, p.224). Blumer, (1969, p.2) following in the footsteps of George Herbert Mead, a social psychologist and key figure in the development of symbolic interactionism, cites three key elements governing this frame of thought:

1. Human beings act toward things on the basis of the meanings that these things have for them;
2. The meaning of such things is derived from, and arises out of, the social interaction that one has with one’s fellows; and
3. These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.

Through these three assumptions, it can be seen that the focus is again placed on human agency where individuals are considered active participants in the development of their social worlds (Parsons 1978; Shalin 1991). Stressing this notion of agency, Mead (1932 [2002]; 1934) explores the concept of the self as one which is temporally and intersubjectively located. The construction of personhood, or a person’s self-concept as he describes, is significantly dependent not just on relationships, but on temporality as well (Crotty 1998; Ezzy 1998). In making this argument, he begins by referring to consciousness as arising only when “organisms” develop “organized attitudes”, or responses towards the objects which guide their behaviors (Ezzy 1998). It is at this point

that the conception of time in the context of action informed by past memories and an anticipated future becomes important, as Ezzy (1998) summarizes here:

Both memories of the past and anticipations of the future are symbolically organized and manipulated to provide a coherent self-concept that serves to direct action. In the same way that a person passes from the present into their own remembered or anticipated actions, they also pass into the remembered or anticipated responses of others. The meanings of past and anticipated events change as a consequence of the reframing effects of role taking during the passage of interaction.

As this passage suggests, a person's self-concept is developed in reaction to the process of constructed meanings based on remembered or anticipated responses to past events of either their own lives, or those of others. In this regard, "role taking" refers to the interchange of perspectives between actors through the construction of experience as rooted in their pasts and futures and thus manifested in a system of symbolic or cultural conventions (such as language or other social processes) specific to a social group (Crotty 1998; Ezzy 1998). The implications this has for symbolic interactionism and thus for this study are then vastly significant. If the self is viewed as a conscious organism rooted in relationships based on temporal and intersubjective experience, and if action and behavior occur as a result of such relationships, then the social structures or processes through which inequality is enacted and institutionalized therefore become evident in the daily encounters of the social actors. A symbolic interactionist approach can in this way prove beneficial in that systematic interpretations of the relationship between self-identity and systems of power based on the symbolic manifestations of shared cultural conventions can be analyzed through the lens of exhibited patterns of inequality and exclusion. The ensuing subsection elaborates these concepts and further discusses the ways in which a symbolic interactionist approach has been used to inform and understand the processes behind exclusionary occurrences specific to Peruvian Andean society.

4.2.2.1 *Symbolic Interactionism and Systems of Power*

As a theoretical perspective which so resolutely focuses on action resulting from daily interactions, symbolic interactionism by its very nature can be seen as an approach dedicated solely to the understanding of micro-level aspects of social organization. Macro-level phenomena, such as patterns of exclusion and uneven power structures are thus often viewed as out of the realm of a symbolic interactionist perspective (Bilton et al. 2002). Contesting this view, Dennis and Martin (2005) argue that symbolic interactionism is quite capable of conceptualizing broader level social structures such as power relations and inequality. Drawing from examples taken from interactionist studies in the fields of deviance and education, they illustrate the ways in which power, in the form of an “authoritative imposition of consequential identities” has been “enacted and institutionalized in real situations” (Dennis and Martin 2005).

Interactionist studies on deviance have garnered significant popularity over recent decades, in particular following the publication of Becker’s (1963) book *Outsiders* which offers an analysis of the various kinds of deviance and those who are labeled as such. His work, in providing a detailed perspective of the deviant, excluded and marginalized, delivers an insightful account of the micro-level implications of imposing labels or identities onto individuals (Orcutt 1983). Of particular interest however, in addition to understanding such micro processes, is the focus on understanding the authoritative mechanisms of macro social structures “...through which individuals are rendered subordinate through legally sanctioned and institutionally established procedures” (Dennis and Martin 2005). Following Durkheim’s (1997 [1893]) ideas concerning the culturally variable patterns of normative behavior as it is enacted through the negotiation of conflict, an interactionist approach taking both micro and macro processes into consideration can serve to focus on the minutiae of how such authority is experienced and ultimately challenged and thus manifested in broader systems of power. The ways in which rules are at first established and subsequently either enforced or resisted, points to these processes of negotiation, usually in terms of compromising the basic values or norms of opposing groups (Dennis and Martin 2005). Here, the emphasis

is on responses to authority, as through rule-making, as they occur and are experienced by people in culturally diverse settings. Becker (1963, p.18) thus explicitly points out the relationship between rule-making, identity distinctions and power relations:

...Differences in the ability to make rules and apply them to other people are essentially power differentials...Those groups whose social position gives them weapons and power are best able to enforce their rules. Distinctions of age, sex, ethnicity and class are all related to differences in power, which accounts for differences in the degree to which groups so distinguished can make rules for others.

Interactionist studies focusing on power relationships can bring relevant insight into the ways in which they are enacted, not just in the daily life of individuals, but also in institutional contexts. Studies of formal educational institutions for instance have also evidenced themes of rules, identities and power (Dennis and Martin 2005). Drawing again from Becker (1955), Dennis and Martin (2005) discuss the ways in which power is reflected in unequal opportunities for education and thus for social mobility. In this context, members of subordinate social groups, such as those belonging to lower classes or other minority groups as in their example, have more limited opportunities towards educational attainment, thereby reinforcing their status as subjugated members of society. Employing an interactionist perspective, the explanation cited focused on the “every day processes of the school”, specifically “how routine, everyday activities in the classrooms reproduced class-based society-wide inequalities in educational attainment levels” (Dennis and Martin 2005). Schools, in these terms are thus viewed as authoritative institutions, where teachers and other educational professionals are in the position to impose certain identities on the students (i.e., cultural, ethnic or religious) through a routine set of activities or rules, and in so doing are defining and reinforcing their social positioning.

Through these examples, it can be seen that symbolic interactionism offers a perspective which is not just limited to micro-level conceptualizations of social processes. In addition to providing a theoretical positioning geared towards understanding individual, and thus local-level aspects of society and social organization, it also offers a way of

discerning patterns of inequality and exclusion as they are manifested in macro-level occurrences, such as through institutional systems of authority and power structures. This theoretical perspective accordingly becomes particularly salient in the context of understanding such processes as they occur in an Andean setting. In this way, an in-depth analysis of bottom-up approaches to managing exclusion, such as from health services as in the case of this study, can be examined from a perspective which provides a mechanism for understanding individual interpretations of inequality and how these are managed and negotiated within a system of institutionalized power relations.

As this study investigates constructions and perceptions of indigenous identities and the ways in which such identities are represented given the specific social and historical experiences of Peruvian Andeans, emphasis is placed on understanding how each of the participants view and interpret their daily lives and interactions with others. This is explored in the context of examining indigenous Andean's health seeking behavior during the maternity and postpartum period as well as exploring the experiences of health professionals and organizers of social development programs (including CHWs and their program coordinators). Here, attention is drawn to the unequal distribution of resources available to community members, health professionals, and social development coordinators in seeking, providing or coordinating maternal health services, and how this is reflected in barriers to access or delivery of quality health care. Similar to the above example of the education system as an authoritative institution, the health system can thus also be viewed as an institution which can either facilitate or impede opportunities for well-being through health attainment as well as social mobility. Professionals operating within the health system, as holders of expert knowledge, and therefore figures of a certain level of authority, are in the position to produce or perpetuate behaviors which can influence the access of indigenous community members to health services, as for instance through ethnic or gender based discrimination. Likewise, community members, through their every day practices and interactions are also in the position to negotiate their way through systems of social stratification, such

as through either resisting or embracing certain social, ethnic or professional identities as a means to increase access to services.

Accordingly, this study examines interpretive conceptualizations of daily life experiences as they are represented in the varying exclusionary relationships embedded into complex systems of power and other social structures specific to the Andean context. This is achieved through the application of a symbolic interactionist rendering of the interplay between the micro and macro-level social processes of Peruvian society. In this regard, an interpretive paradigm and a symbolic interactionist theoretical perspective have been implemented to guide the employment of a rigorous and systematic mode of inquiry. Therefore, in order to actualize this study, a methodology has been employed that considers socially constructed interpretations of reality as they are made meaningful through social interactions.

4.3 Study Methodology: Constructivist Grounded Theory and Case Study Research

In following the philosophical underpinnings driving this investigation, a combination of constructivist grounded theory with case study research has been adopted as the study methodology. The case study method was used in the initial stage of research in order to define the starting unit of analysis and guide data collection techniques. Constructivist grounded theory was then used to further direct data collection and subsequent analysis and theory construction. While both methodologies were used in an integrated fashion as will be elaborated throughout this section, it is important to note, that the overarching methodology guiding this investigation is constructivist grounded theory, with case study used mainly for purposes of identifying the object of study. The decision to use these combined methodological strategies was governed by both theoretical as well as practical reasons. Constructivist grounded theory, as developed by Charmaz (Charmaz 2003; 2006), allows for a flexible yet systematic approach to observing and interpreting the meaning behind social processes, while the case study method, when adapted to an interpretive paradigm, provides the opportunity to generate insights based on observed relationships within the bounded case or cases (Steenhuis and de Bruijn n.d.). The

complimentary nature of these two approaches and the rationale behind the decision to employ this methodology will be specified following an overview of the development of the varying schools of grounded theory as they lead up to Charmaz' (Charmaz 2003; 2006) constructivist version.

4.3.1 Development of Grounded Theory Approaches

Grounded theory in its original form was first introduced in the mid-1960s by American sociologists Barney Glaser and Anselm Strauss through their collaborative research on death and dying in hospitals. The resultant book from their study, *Awareness of Dying* (Glaser and Strauss 1965), signified the development of this new method and thus the first time it was applied. While closely observing the experiences of terminally ill patients in a variety of hospital settings, and the ways in which death was acknowledged by both patients and health professionals, Glaser and Strauss began to employ specific systematic strategies based on constant comparison of their collected data. These strategies, first referred to as the “constant comparative method”³⁰ “...gave their data explicit analytic treatment and produced theoretical analyses of the organization and temporal order of dying” (Charmaz 2006, p.4). Just two years later, they detailed this new approach through the publishing of their landmark book, *The Discovery of Grounded Theory* (Glaser and Strauss 1967).

The systematic strategies articulated in the *Discovery* text called for a departure from the tradition of quantitative research paradigms which were dominating sociological studies at the time (Charmaz 2006). The new grounded theory approach, commonly referred to as *classic grounded theory*, thus promoted the departure of quantitative methods and instead advocated for the discovery of theory from research grounded in the data itself. Specifically, classic grounded theory was established as a means to “...develop a theory that emerges from and is therefore connected to the reality the theory is developed to explain” (Cohen and Crabtree 2006). Rather than relying on *deductive* strategies which

³⁰ The constant comparative method will be described in more detail in section 4.11.1 of this chapter in terms of detailing how it was used in the analysis of the study data.

focused on replication and verification, grounded theory delineated data collecting methods which aimed to *inductively* produce theoretical explanations about participants' patterns of behavior.³¹ The purpose then of introducing this new form of research was to conceptualize issues of importance through an empirical analysis of participants' behavior (Breckenridge et al. 2012). Glaser and Strauss' grounded theory thus introduced a systematic way to conduct qualitative research by combining the richness of interpretive understandings of social processes with the logic and rigor characteristic of quantitative methods (Walker and Myrick 2006).

The steps that Glaser and Strauss (Glaser and Strauss 1967) prescribed to achieve grounded theory in practice include:

- Simultaneous involvement in data collection and analysis
- Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses
- Using the constant comparative method, which involves making comparisons during each stage of the analysis
- Advancing theory development during each step of data collection and analysis
- Memo-writing to elaborate categories, specify their properties, define relationships between categories, and identify gaps
- Sampling aimed toward theory construction, not for population representativeness
- Conducting the literature review *after* developing an independent analysis

Grounded theory thus begins with a research situation where the task of the researcher is to understand the social phenomena in question through close involvement with the data. This involves the primary step of collecting qualitative data, then constructing a set of analytic codes and categories which can be compared (Dick 2005). Initially this

³¹ A deductive approach refers to the scientific process whereby a conclusion is drawn from an established set of premises. This is in contrast to the inductive approach which assumes that a general law is established by accumulating strong evidence for a conclusion (Crotty 1998).

comparison is made between data, or individual pieces of information and consequently progresses to comparisons between interpretations of this data as defined by the designated codes and categories (Mills et al. 2006). In following these procedures, theory that is closely connected to the data should ultimately begin to emerge through gradual abstraction of such data (Reichertz 2009).

Since its initial inception as a qualitative research methodology, several modified forms of the approach have been developed. Most notably, the divergence from Glaser and Strauss' original grounded theory can be characterized by disagreement between the two authors over differing perspectives on the procedures of analysis. Specifically, such perspectives concerned the ways in which the basic research processes were carried out and the conflicting methodological assumptions behind these processes (Walker and Myrick 2006). The split between the two authors became most obvious with the publication of Strauss' (1987) later writings, and subsequently those he co-authored with Juliet M. Corbin (Corbin and Strauss 1990; Strauss and Corbin 1990). Where classic grounded theory, as originally introduced, focuses on the emergence of theory that is implicit in the data, this in itself implying the existence of an objective truth waiting to be discovered (Breckenridge et al. 2012; Charmaz 2003; Crotty 1998), Strauss, and later Strauss and Corbin, began to emphasize verification and validation of research through more technical procedures (Breckenridge et al. 2012; Dick 2005), that is, through highlighting the importance of a "*rule-governed* and *replicable* production of new and *valid* knowledge" (Reichertz 2009, p.3). Critics of these later approaches, including Glaser (1992a) himself, purported that rather than allowing theory to emerge, these analysis strategies instead would "...force data and analysis into preconceived categories and, thus, contradict fundamental tenets of grounded theory (Charmaz 2006).

Disagreements over whether theory "emerges" or is "forced" from the data, is thus one of the key distinguishing factors between the divergent approaches and is reflective of the underlying positions of each author (Walker and Myrick 2006). Strauss (1987) and Strauss and Corbin's (1990) version of grounded theory, in contrast to the classic formulation, rejects Glaser's positivistic belief in a "pre-existing reality" (Mills et al.

2006). Rather than striving to discover an emergent objective truth, their method instead places emphasis on the *interpretation* of reality based on a multiplicity of perspectives, thus implicitly rooting them in a relativist ontological standing (Hallberg 2006; Mills et al. 2006).

In addition to the issues of validation and verification of data through prescriptive analytic techniques, and “forcing versus emerging” theory, similar disagreements occur over the extent to which the researcher should be engaged with the data, such as through interactions between the researcher and participants, and the degree to which prior theoretical knowledge is considered a necessary precursor towards the development of theory (Dick 2005; Reichertz 2009). In regards to interactions between the researcher and participants, Strauss and Corbin discuss the researcher’s personal and professional experiences in terms of theoretical sensitivity³² as an important contribution towards abstracting theory from data (Hallberg 2006). Debates over prior theoretical knowledge in conducting grounded theory studies equally cause tensions between the varying approaches. Both Glaser and Strauss acknowledge that the researcher is not expected to begin data collection without any previous knowledge or ideas (Heath and Cowley 2004). Nonetheless, classic grounded theory dictated that partaking in any review of the literature further to what the researcher has already been exposed to could risk contaminating the analysis, and in turn inhibiting the emergence of a true and objective theory (Mills et al. 2006). Strauss and Corbin (1998) on the other hand, recognized the usefulness of engaging proactively with the literature. Early use of the literature, as they identified it, could prove beneficial towards not only stimulating further analysis based on shared experiences, but more so as providing “...another voice contributing to the researcher’s theoretical reconstruction” (Mills et al. 2006, p.3). It is thus within this context, in following the relativist underpinnings of Strauss and Corbin’s methodology, that a constructivist alternative to the classic grounded theory strategies began to take root.

³² Theoretical sensitivity refers to the researcher’s awareness of the subtleties of the data (Charmaz 2006) . This is discussed in more detail in section 4.4.1 of this chapter.

4.3.2 Constructivist Grounded Theory

Charmaz (2003; 2006), a student of both Glaser and Strauss, offers a modified form of grounded theory which is based on constructivist modes of understanding. In line with relativism, a constructivist paradigm assumes that there are multiple social realities rather than one objective, universal truth (Crotty 1998; Hallberg 2006). Constructivist grounded theory, as developed by Charmaz (Charmaz 2003; 2006), builds on the symbolic interactionist theoretical perspective and emphasizes an ongoing interaction between the researcher and participant as co-creators of meaning. In contrast to classic grounded theory, where the intent is to allow theory to emerge from data which is separate from both the observer and observed, Charmaz' rendering of grounded theory poses that theories are *constructed* from the data rather than *discovered*. Researchers, as members of the same world in which they are studying, construct grounded theories based on their "...past and present involvements and interactions with people, perspectives, and research practices" (Charmaz 2006, p.10). The constructivist mode of grounded theory is thus centered on an interpretive understanding of the social world which arises from the interactive experiences and views of researchers and participants alike (Charmaz 2003). The researcher is responsible for maintaining a strong degree of reflexivity so as to study the ways in which participants' responses or actions may be influenced by the interests, position and even presence of the researcher (Charmaz 2006). A reflexive stance such as this informs how the research is conducted and how the researcher relates to the participants. The way the researcher and participants perceive one another can thus determine how the interaction will continue and consequently how data is collected and subsequently interpreted (Hallberg 2006).

The underlying philosophical assumptions inherent in constructivist grounded theory hence offer a way of conducting research that is in line with a symbolic interactionist perspective, as outlined in Section 4.2.2 of this chapter. By viewing social life as a series of processes and based on multiple constructed social realities, Charmaz (2006) introduces her methodology as one which is focused on understanding the relationships between meaning, action and social processes. Building on the strategies originally

introduced by Glaser and Strauss (1967), Strauss (1987) and Strauss and Corbin (Strauss and Corbin 1990; 1998), Charmaz (2006) proposes an altered version of methods which she emphasizes are to be used as flexible guidelines for theory development rather than strict methodological rules. Moving away from the positivist foundations of her predecessors,³³ she presents grounded theory methods as a set of principles and practices which can be adopted and adapted to meet the needs of the specific research setting (Charmaz 2006). Coding, category building, memo-writing and sampling for theoretical development continue along with the constant comparative method as necessary components in constructivist grounded theory (Figure 10). Charmaz (2006) also advocates the gathering of full and detailed data through a process of immersion. Suggesting the use of a coding language that is active,³⁴ she incites maintaining the participants' voice throughout data collection, analysis and theory construction. Charmaz further outlines a strategy of writing as an analytic tool which is intended to invoke the narrative experiences of participants, thus preserving the temporal and situational contexts of the social worlds under study (Charmaz 2006; Mills et al. 2006). By ensuring the presence of the participant's voice while at the same time maintaining reflexivity, the researcher can construct a theoretical explanation that is closely grounded in the data. As such, the resultant theory in a constructivist grounded theory study is often substantive in nature, that is, an analytical interpretation of a defined problem of a particular area (Charmaz 2006; Creswell 1998). This type of theory is not only relevant to the particular substantive area under study, but also preserves the contextual environment of the research setting.

³³ Though Strauss and Corbin (1990) have referred to relativist notions in guiding their methodology, Charmaz (2006) has argued that their strict adherence to standardized analytic techniques places them in a positivistic stance, assuming the existence of an external reality (Charmaz 2003; Heath and Cowley 2004; Mills et al. 2006).

³⁴ The use of active coding techniques is discussed in greater detail in section 4.11.1 of this chapter.

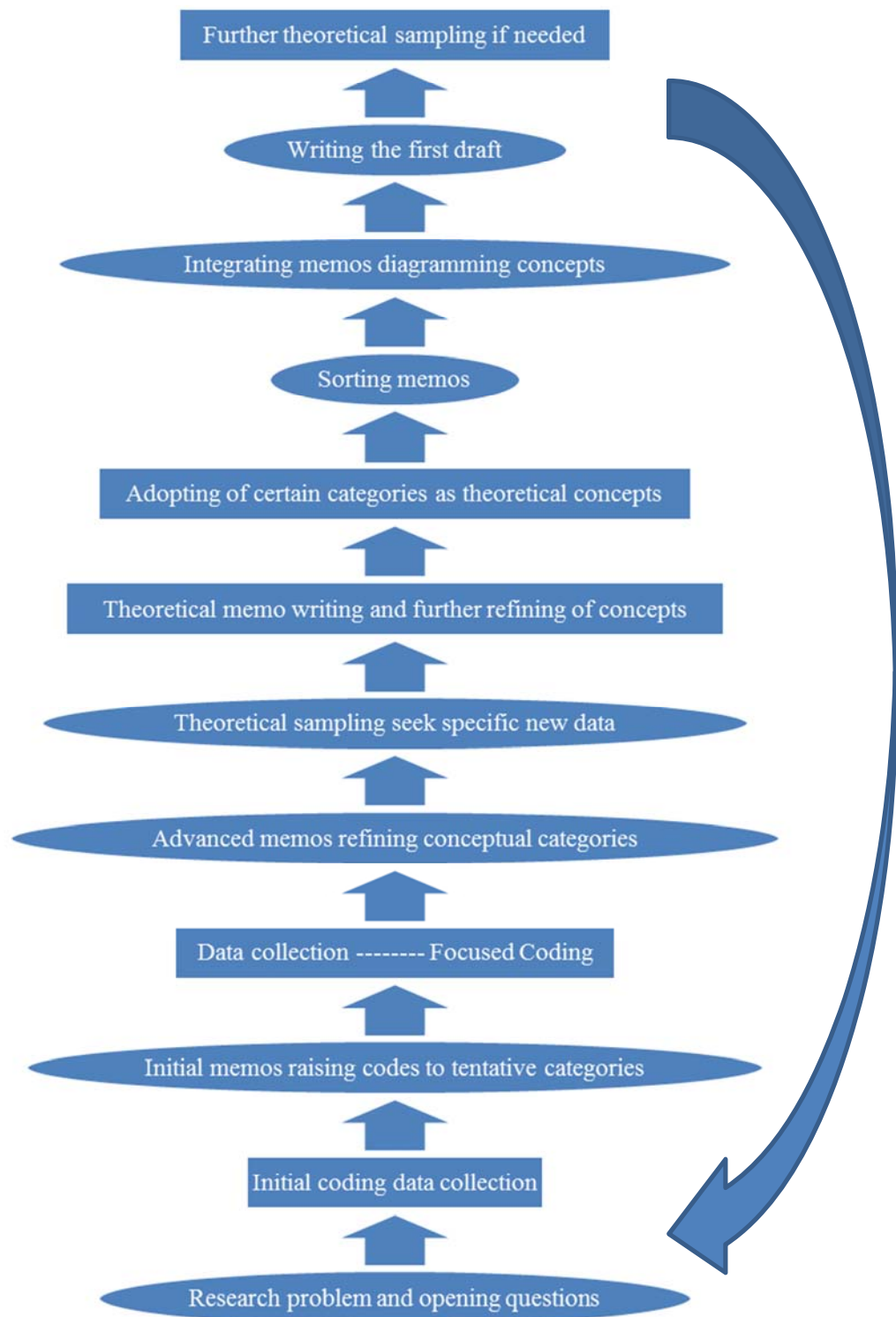


Figure 10: The constructivist grounded theory process

The approaches to data gathering and analysis introduced in constructivist grounded theory accordingly allow for a flexible yet systematic way to interpret social processes and the meanings behind them as perceived by both the researcher and participants. By engaging with the data in a way that is congruent with the interpretive principles characteristic of a symbolic interactionist theoretical perspective, constructivist grounded theory equips the researcher with a methodological toolkit that can thus be used to develop a relevant substantive theory. Thus, given the theoretical perspectives underpinning this investigation, as have been detailed in the preceding sections of this chapter, constructivist grounded theory appropriately provides a version of grounded theory that is closely aligned with the ontological and epistemological assumptions driving this study. In considering the varied forms of grounded theory that have been developed since its original introduction, this study maintains that Charmaz' version provides both the flexibility and rigor necessary to interpret the social worlds of Andean peoples, specifically those involved in the utilization, delivery or coordination of maternal health services in rural Andean communities of Peru. It is at this point, by defining the contextually bounded area of the study, that the benefits of integrating case study research with constructivist grounded theory become particularly salient.

4.3.3 Integrating Case Study Research into the Construction of a Grounded Theory Study

The process of induction, or building a theory that is grounded in data, can be further enriched by applying the canons of qualitative case study research. The case study, as defined by Baxter and Jack (2008, p.544) "...is an approach to research that facilitates exploration of a phenomenon within its context using a variety of data sources". Also, as Yin (2003, p.xi) writes, case study is an appropriate method "when investigators either desire or are forced by circumstances (a) to define research topics broadly and not narrowly, (b) to cover contextual or complex multivariate conditions and not just isolated variables, and (c) to rely on multiple and not singular sources of evidence". Case studies can therefore typically consist of a combination of data collection methods such as interviews, observations and textual analysis. Through both these definitions,

case study research can be seen as a strategy to understanding social phenomena through the use of multiple data collection methods and to aid the researcher in defining the variables of the research topic. In short, case study research is generally proposed as a means to gain an in-depth understanding of social phenomena as it occurs in a “real-life” setting (Dobson 1999). Similar to grounded theory, when applied rigorously, the process can be highly iterative and thus closely tied to the data, thereby producing a robust and informed understanding of the issues under investigation (Eisenhardt 1989).

Case study design on its own is not necessarily qualitative. In fact, in its original form it stems from positivistic assumptions that are not readily identifiable with an interpretive approach (Andrade 2009). Yin’s (1994; 2003) writings on case study design are often cited most frequently when defining the processes of conducting this form of research. The procedures he outlines are largely prescriptive and hold many similarities to the methods used when conducting hypothesis based experimental research. As such, they are geared more towards a deductive approach rather than inductive (Steenhuis and de Bruijn n.d.). Classic case study research for example is based on the notion that theory development is an essential first step when preparing to collect data (Yin 1994). This assertion quite clearly contradicts the basic tenets of grounded theory where theory generation or construction based on findings from data collection is the final aim of conducting research (Steenhuis and de Bruijn n.d.) .

It is nevertheless possible to adapt the case study design to meet the principles of grounded theory. This occurs through adopting a qualitative case study methodology aimed at theory construction and based on an interpretive mode of understanding. It is important to note that when combining an inherently inductive method such as grounded theory, in particular constructivist grounded theory, with a strategy that has been known to have positivistic and deductive underpinnings, it becomes essential to exercise caution and reflexivity while developing the substantive grounded theory.³⁵ Used carefully

³⁵ Reflexivity is discussed in more detail in Section 4.4.2 of this chapter.

however, case study can prove complimentary to interpretive research aimed at theory construction.

First, as Creswell (1998) suggests, it is useful to distinguish the type of case study to be used and whether the case in question is to be viewed as the “object of study” or as the methodology itself. For the purposes of this investigation, the case thus refers specifically to the object of study, or unit of analysis. Case study research in terms of the methodology can in general be conducted in a variety of ways. Stake (2005) for instance describes three forms of case study, the intrinsic case study, the instrumental case study and the collective case study. The intrinsic case study is the study of a unique case undertaken because the case itself is of interest rather than because it can be representative of other cases. Instrumental case studies on the other hand are used to provide insight into an issue in order to refine a pre-existing theory. The case in an instrumental case study thus becomes of “secondary interest”, playing “a supportive role...[that] facilitates our understanding of something else” (Stake 2005, p.445). Collective case studies accordingly are used to study several cases (Stake 2005). As such, case study research can serve to provide either descriptions or explanations of phenomena which can be further used to develop theory or to test theory (Dobson 1999). In consideration of the three types of case study, this study adopts an intrinsic case study approach which focuses on acquiring in-depth descriptions of the social phenomena leading to the development of theory through an interpretive mode of analysis. In this way, the case is not of secondary interest, but instead of equal interest to the theory to be constructed.

Integrating case study with a constructivist grounded theory approach which by its very nature already incorporates interpretivist ideals is in this regard well suited towards the construction of a substantive theory. Eisenhardt (1989, p.547) for instance, cites three major strengths for using case data to build a grounded theory, as paraphrased here:

1. Theory building from cases is likely to generate novel theory. This occurs because “creative insight often arises from the juxtaposition of paradoxical

evidence...[and]...building theory from case studies centers directly on this kind of juxtaposition...Attempts to reconcile evidence across cases, types of data, and different investigators, and between cases and literature increases the likelihood of creative reframing into a new theoretical vision”.

2. The theory is “...likely to be testable with constructs that can be readily measured and hypotheses that can be proven false”.
3. The theory that results is “...likely to be empirically valid”. This is so because “...the theory building process is so intimately tied with evidence that it is very likely that the resultant theory will be consistent with empirical observation”.

Combining case study research with grounded theory thereby provides a means to construct theory which is novel, testable and empirically valid. As this investigation itself is geared primarily towards developing an interpretive understanding of the social processes in question, testability and validity are not the main goals of this study. However, their inclusion as strengths to this combined methodological strategy grants a greater degree of utility and therefore robustness to such an approach. Further, case studies prove particularly useful for the study of lesser developed research areas where a holistic, in-depth and context-specific examination of a dynamic research setting can take place because they provide a systematic way to define the temporal and spatial boundaries of the object under study,³⁶ (Creswell 1998; Dobson 1999). The generation or construction of a substantive theory is thus readily attainable through this combined methodological approach. Accordingly, intrinsic case study methods drawing on multiple sources of information including semi-structured interviews, participant-observation, and document review are used to both determine the object of study and drive initial data collection. Constructivist grounded theory implemented as the overarching methodology is therefore also used, but as a guiding “toolkit” to collect data and analyze the findings in a rigorous and systematic way. Used together in this fashion,

³⁶ Temporal and spatial boundaries of the case will be discussed in more detail in Section 4.6 of this chapter.

this methodological approach can provide a means of gaining deep insight into the complex social processes occurring within a bound but dynamic study setting. As such, it can potentially be an advantageous way to identify what is experienced within the research situation from the perspectives of those experiencing it.

4.3.4 Rationale behind Methodological Choices

Given the philosophical assumptions and theoretical positioning guiding this investigation as have been described thus far, constructivist grounded theory combined with case study research was decided to be the most suitable option for this study. Alternative research methodologies within the interpretivist paradigm were however equally weighed during the design stages of this project. In doing so, approaches such as ethnography and phenomenology were considered. In many respects, both of these alternate methodologies are comparable to grounded theory and case study as they all belong to the qualitative tradition of inquiry (Creswell 1998). Ethnography for instance, utilized most often within the discipline of anthropology, is a qualitative approach which aims to describe and interpret a cultural or social group through close observation and immersion into that group (Charmaz 2006; Creswell 1998; Crotty 1998). As a research process, it normally involves prolonged exposure to the behavior patterns and customs of the group in question (Creswell 1998). The researcher conducting an ethnographic study attempts to learn both the implicit and explicit meanings behind the daily experiences and interactions of the study group as they are expressed through cultural forms of expression, such as language or ritual behavior (Charmaz 2006; Creswell 1998).

Phenomenology, similarly, is geared towards understanding a phenomenon through describing and interpreting the lived experiences of individuals who have undergone or been involved in the particular phenomenon (Creswell 1998). Rooted in the social and human sciences, it was a movement which originated as a way to go back to the very basics, or to cite Husserl's famous maxim, to go "back to the things themselves" (Creswell 1998, cited in Crotty 1998, p.78). In this case, the "things" in question refer to

the phenomena that are immediately experienced by conscious human beings (Crotty 1998). Closely related to classic grounded theory, it is an approach which calls for the suspension of all judgments, or prevailing understandings so as to provide the researcher with a way to obtain an understanding of the experience through sole reliance on "...intuition, imagination, and universal structures" (Creswell 1998, p.52). Thus, as a methodology, it examines the structures inherent in human consciousness in order to understand the meanings of these experiences (Polkinghorne 1989). Data collection and analysis in phenomenology are accordingly based on techniques of reduction, that is, through analyzing specific statements and themes to search for possible associations or related meanings (Creswell 1998).

Many similarities between these approaches are apparent; however it is the differences between them rather than the similarities which proved the ultimate deciding factor in adopting the chosen methodology. As Creswell (1998) points out, the fundamental differences between each of these modes of inquiry rest on the primary objectives of the study, or what it is that is ultimately trying to be accomplished. Ethnography and phenomenology in this instance are directed towards very different goals with the former focusing on exploring social groups through immersion and detailed description, and the latter aimed at understanding individual experiences of phenomena through a strategy of reduction (Creswell 1998). Further, both ethnography and phenomenology stress description over explanation, in contrast to grounded theory which as has been described, aims to develop explanations of social processes through either the emergence or construction of theory. Also, phenomenology, in particular when used within the field of psychology, often emphasizes the individual over that of the collective group. As such it looks to derive universal structures based on individual descriptions of experience rather than centering an analysis on the situation as a whole (Creswell 1998).

Ethnography with its emphasis on group and situational meanings, rather than the individually focused psychological phenomenology strategy, situates itself more closely to the stated goals of this study. Despite the inherent strengths of an ethnographic

approach, it was ultimately considered inappropriate for this investigation. This is primarily due to logistical reasons concerning limitations over the amount of time and finances available for data collection. As one of the core techniques of conducting ethnography is to experience the day to day lives of the participants along with them in order to develop an emic, or inside understanding of their social worlds, this methodology is most efficient when long term exposure to the group is possible. As such, ethnography, as a methodology in its purest form involves at least six to eighteen months of intensive fieldwork if not longer (Atkinson et al. 2001). In consideration of these constraints to the length of the field period and thus data collection for this investigation, it was decided to use an approach that could make use of the positive attributes of ethnography, such as close observation and detailed description of the participants' lived experiences, while at the same time allowing for a more succinct means to collect and analyze data. Grounded theory combined with case study was hence deemed more suitable than either of the alternate approaches because together they provide a way to identify the interrelationship between individual experiences with greater group dynamics as they are interpreted from an insider's point of view, while at the same time allowing for multiple qualitative data collection methods within a predefined and bound setting.

4.4 The Role of the Researcher

Prior to undertaking field research and employing the methodological strategies above, it is necessary for the researcher to be aware of his or her own role in the research setting and the impact this can have on the investigation process. In studies operating within an interpretive paradigm, in particular constructivist grounded theory studies; consistent emphasis is placed on researcher-participant interactions, thus resulting in data that is constructed through the mutual interplay of both (Charmaz 2006). The researcher consequently plays a vital part in shaping the data and therefore the outcome of the investigation. The role of the researcher and the ways in which varying assumptions and perceptions over this role may or may not influence all phases of the investigation, from

design to dissemination, is thus discussed in terms of issues relating to the importance of researcher positionality, theoretical sensitivity and reflexivity.

4.4.1 Maintaining Researcher Positionality and Theoretical Sensitivity

The concept of researcher positionality is one which plays a substantial role in the design and implementation of qualitative studies. Several authors have in fact called on researchers to explicitly state what their intended positioning is to be throughout the study process (Jackson 1993; Rose 1997; Smith 1993). Positionality in this regard refers to the stance that is adopted while conducting a study and also to the awareness one has of the ways in which the researcher's own views and experiences may alter his or her relationships with the participants, and consequently the data (Charmaz 2006; Chiseri-Strater 1996). For qualitative researchers, positionality can thus become part of the data itself. It is a concept which includes attributes of identity, such as ethnicity, gender or social status, as well as personal or professional experiences, all of which have the likelihood to predispose each actor with a certain degree of bias, whether intentional or not. As such, the interactions between the researcher and participants may be influenced by the subtleties and nuances inherent in these given attributes (Chiseri-Strater 1996). Positionality in this way has the potential to shape encounters and outcomes of data collection in that it can determine how a researcher is perceived and thus received by the participants. (Chiseri-Strater 1996). The process of analysis can equally be impacted given the researcher's own assumptions and claims as to what may or may not be socially significant to the life-worlds of the participants (Mills et al. 2006).

Thus, in order to ensure well-balanced research which takes these issues into consideration, it becomes important for the researcher to develop and maintain a sense of theoretical sensitivity throughout the study process. A popular concept in grounded theory, theoretical sensitivity, as characterized by Strauss and Corbin (1990) is a multi-dimensional concept which refers to the level of insight a researcher has into the subtleties of meaning within the research situation. It is, as they describe, a personal quality comprising these attributes of insight and equipping the researcher with "...the

ability to give meaning to the data, the capacity to understand, and capability to separate the pertinent from that which isn't" (Strauss and Corbin 1990, p.41-42). It is a way of attuning oneself to the complexities and nuances embedded in the participants' words and actions (Mills et al. 2006).

Issues of theoretical sensitivity become markedly salient when considering the varying forms of grounded theory, in particular in terms of debates over the literature review. Classic grounded theory for instance stipulates that researchers should enter the field with as little prior knowledge into the substantive area of study as possible. That is, the researcher should strive to maintain a certain degree of objectivity so as to remain sensitive to the data which is expected to emerge (Glaser 1978). This way, the likelihood of legitimate theoretical discovery during the study process is enhanced, thus enabling the researcher to "...record events and detect happenings without first having them filtered through and squared with pre-existing hypothesis and biases" (Glaser 1978, p.3).

The notion of maintaining objectivity through limiting the literature review prior to data collection equally raises the issue of the "emergent" versus "forced" debate highlighted previously. Classic grounded theorists' claims that theoretical sensitivity in its true form can only be achieved through the researcher entering the field as a "blank slate" have been heavily contested (Urquhart 2013). Glaser and Strauss (1967) even stated in their original publication that researchers are not expected to approach reality as a *tabula rasa* (blank slate), but rather should focus more on setting aside or suspending what knowledge and experience they do have in order to locate data that is not clouded by preconceptions (Urquhart 2013; Walls et al. 2010). Emphasis in this version of grounded theory is in this manner placed on the data as a separate entity from the researcher, while situating the participant as a holder of information that can be accessed through the researcher's full immersion, thus enhancing the level of theoretical sensitivity (Mills et al. 2006). The researcher, in this view is considered an "expert", who through the use and knowledge of theoretical sensitivity has the ability to inductively develop theory from the general concepts that begin to emerge from the data (Glaser 1978). As later proponents of grounded theory (Charmaz 2006; Strauss and Corbin 1990; Strauss and

Corbin 1998) began to advocate the role of the researcher as co-constructor of data and thus an equal participant, techniques for enhancing theoretical sensitivity – particularly during the analysis phase – were developed which further shaped the researcher-participant relationship (Mills et al. 2006). In this regard, it can be argued that the researcher was to be viewed not as separate from the data and participants, but rather as like contributors and therefore acting as yet another source of data within the research setting (Urquhart 2013). Strauss and Corbin's rigid analysis methods however lead to the previously discussed criticisms over forcing theoretical insight onto the otherwise emergent data (Glaser 1992b). Their response to this claim though was to emphatically assert that the ideas generated from their techniques were not to be considered an embodiment of more data, but rather they served to encourage reflection so as to provide more ways of sensitizing oneself to the data (Mills et al. 2006).

In acknowledging these debates, Charmaz (2006, p.135), proposes a way of maintaining theoretical sensitivity through acts of theorizing, or as she writes, to "...stop the flow of studied experience and take it apart". Building on the notion of the researcher as a co-constructor of data, she describes the process of constructing theory in terms of "theoretical playfulness" (p.135), or probing into the complexities of experience by remaining open to the unexpected. This form of theoretical sensitivity, as she suggests, "expands [the researcher's] view of studied life and subsequently of theoretical possibilities" (p.136).

A researcher's positionality and degree of theoretical sensitivity can thus potentially have great impact on the outcomes of the research process. Accordingly, such concepts further highlight the question of what a "grounded theory" actually refers to. That is, what it is that actually "grounds" the grounded theory? The above stated debates concerning these matters suggest this could either refer to pre-existing knowledge or to the data itself (Mills et al. 2006). As such, it becomes necessary for the researcher to not only maintain sensitivity to the data within the research environment, including the researcher's own role in the collection and subsequent analysis of this data, but also to what the intended outcome of the study is to be. This can be dealt with by explicitly

calling on the fundamental ontological and epistemological assumptions driving the study. Therefore, in following a symbolic interactionist perspective throughout this research, the techniques used in this study are geared towards constructing an interpretation of the data based on the perspectives of the researcher as well as those of the participants. The substantive theory resulting from this study is therefore grounded in data which by its very nature as inclusive of human experience is already embedded with pre-existing knowledge. In this regard, engaging with the study process should involve reflecting on the personal experiences of both researcher and participants. The ways in which these issues can influence study outcomes are thus subsequently detailed in the context of understanding the role reflexivity has played throughout this investigation.

4.4.2 Reflexivity: Constructing Meaning through Social Interaction

To be aware of one's positionality and sensitivity in a study setting requires the researcher to reflect on the research experience as a whole before, during and after entrance to the field. As the researcher's values, beliefs and previous experiences all have the potential to influence the study process, reflexivity accordingly becomes an integral feature of any investigation. Charmaz (2006, p.188) appropriately defines reflexivity as:

The researcher's scrutiny of his or her research experience, decisions, and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interests, positions and assumptions influenced inquiry.

Further, she adds that engaging in a reflective practice throughout a study "...informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports" (Charmaz 2006, p.189). Reflexivity in these terms includes attributes which are visibly congruent to the interpretive principles of symbolic interactionism and constructivist grounded theory, as well as positionality and theoretical sensitivity. With meaning, and therefore reality occurring as co-constructions resulting from the shared interactions between the individuals involved in the research

setting, including the researcher, maintaining a reflexive stance thus became of utmost importance during all stages of this investigation. In the first instance, taking consideration of researcher positionality provided a means to critically assess the ways in which the researcher would be perceived by the study participants and equally received into the communities. Issues pertaining to the complexities of conducting research in one's own native country as was the case in this study were thus brought to light.³⁷ In the second instance, and of equal pertinence, is the importance of maintaining awareness of matters which might arise when conducting research in the LMICs of the "Global South". In this case, it was necessary to pay attention to concerns over of representation, in particular how undertaking research from a "Global North" or high income country perspective should be approached in a Southern context.

4.4.2.1 Conducting Research as a "Native Investigator"

Though principally a topic of interest within the discipline of anthropology and therefore more often in ethnographic research, the challenges associated with conducting research as a "native investigator" came to bear important implications for this study. As this study focuses on issues of identity, including ethnic and cultural representations (and negotiations) of identities, discerning the ways in which self-identifying as ethnically Peruvian would influence the study process and outcomes marked a primary concern. Admittedly, the term "native investigator", or "native anthropologist", as it has more commonly been referred to, can be problematic in that it is loaded with essentialist³⁸ connotations (Abu-Lughod 1991). It is however a concept that has gained acknowledgment and wide use amongst NGO practitioners and academics working in indigenous research settings (Garcia 2005). As such, it was important to reflect on how a researcher who self-identifies as Peruvian would be received by the study participants. This also included reflecting on how identifying as Peruvian would affect issues of

³⁷ The researcher holds dual Peruvian-American citizenship and has lived in Peru on several occasions.

³⁸ Essentialism refers to the philosophical notion that there is an essential reality to every entity, and therefore a specific set of attributes assigned to it (Crotty 1998).

access or bias during data collection and equally how this identity would impact the analysis phase of this study.

As a Peruvian-American researcher of *criollo* ancestry with familial ties to both the coastal capital as well as the highlands, the possibility of assumptions over “authenticity” raised potential difficulties for conducting fieldwork. Reflecting on similar concerns, Garcia (2005, p.16) discusses some of the ramifications these issues had during her own research in the Peruvian Andes:

Acknowledging that Peru is the country of my birth and the Andes the land of my grandfather, many Andeans would use phrases such as “you are like us [Eres como nosotros], “You are authentic [Eres auténtica], and “You have Andean blood, like us [Tienes sangre Andina, como nosotros].” Significantly these phrases were usually followed by a statement about how and why this identity tied me to a more socially responsible kind of research. Because I was born in Peru, I was somehow more intimately connected, I understood more completely, and I would contribute (both concretely with material resources and abstractly with academic contributions) more fully to the community.

Claims to authenticity over identity in this context can have the potential to increase acceptance into a research setting. At the same time, feelings of consternation or tensions over these same identifying markers could equally invite instances of mistrust or refused participation. In the case of acceptance into the research setting, Garcia’s experience highlights how her identity as a Peruvian of Andean ancestry both situated her as having commonalities with her study participants, as well as someone who because of this common identity would be expected to feel more responsibility towards them and thus hold an increased sense of duty towards their fair representation in her study outcome. In the case of this study, identifying as a dual-national inclusive of Andean heritage facilitated this same form of authenticity thereby resulting in feeling commonalities with the participants and using these to help gain access to the communities.

Of equal importance to the implications surrounding social and ethnic identity concerned perceptions over having both *Limeñan*³⁹ and American ties, and the potential these had for impeding access to participants. Maintaining awareness of the social histories of the research environment and the expectations over what the role as an investigator should be, whether native or not, was thus a critical factor in regards to the characterization and outcomes of the researcher-participant relationship. The methodological significance of this further highlighted issues pertaining to the emic-etic, or insider-outsider divide in terms data collection and analysis. Sharing common ethnic and cultural ancestry with the study participants, it would be reasonable to assume that a native investigator should have at least some degree of an insider's perspective into the study setting. A researcher viewing data from an emic perspective however, also possibly runs the risk of overlooking certain taken-for-granted assumptions inherent in social behavior, such as those represented by language nuances or other culturally based generalizations as made implicitly familiar to an inside researcher (Kanuha 2000). An emic view as such stands in contrast to the etic, or "outsider's" perspective which is more objective and distant and thus further removed from the subtleties of culturally specific behaviors (Headland 1990). As a researcher approaching data from both an emic and an etic positioning, mediating this sometimes conflicting duality posed further necessities for self-reflection throughout the study process. The biases or predispositions inherent in both these perspectives thus required a need to consider the ways in which participants should be represented in the outcome of this study, above all in terms of an outside investigator reporting on aspects specifically characteristic to the "Global South".

4.4.2.2 On Issues of Representation and Avoiding "Western" Bias

A key concern when undertaking international studies, in particular those in which the researcher comes from a Western context, revolves around issues of representation. In pursuing studies in low or middle income countries, the risk of conducting exploitative research or perpetuating neocolonial representations of authority and control, signifies a

³⁹ "Limeñan" refers to someone who is from Lima, Peru's capital city.

greater need for being attentive to histories of oppression or domination in these regions (Sultana 2007). In this regard, the researcher is presented with specific challenges which need to be negotiated while investigating issues of marginalization and inequalities in order to avoid Western bias or ethnocentrism. Concerns over preventing essentialisms, particularly when it comes to written representations of the lives of the study participants, thus requires the researcher to further engage with the study situation in a reflective and analytical manner.

As issues such as distinct ethnic, class and other social divisions (i.e., material, education level, and gender) remain acute markers of difference in low and middle income countries, questioning the hegemony of the researcher-participant, or researcher-subject dichotomy thus necessitates maintaining awareness over the salient nature of such categories (Kanuha 2000). In challenging the essentialist features of this dichotomous relationship, a researcher approaching the study environment from a high income country perspective thus walks a fine line between portraying the participants as autonomous actors while at the same time avoiding the perpetuation of ethnocentric interpretations of social behaviors (Kanuha 2000). The researcher therefore has the added responsibility to situate him or herself within the emic-etic, or insider-outsider divide in a manner which does not increase the likelihood of permeating such notions of bias. Acknowledging the ways in which data collection, analysis and ultimately dissemination through written reports can be entrenched in unequal power relations thus commands paying close attention to the processes and politics of knowledge construction (Sultana 2007). Questioning pre-determined categories of identity involves a critical examination of the power relations inherent in the research environment, including, in this regard both the greater country-specific and historically defined power relations as represented by varying identity markers, as well as those embedded in the relationship between the researcher and participant (Sultana 2007).

Thus, maintaining awareness of the role of the researcher in terms of positionality, theoretical sensitivity and reflexivity are essential aspects of any study. This investigation, in operating within a symbolic interactionist theoretical perspective where

interpretive understandings of social relationships are highlighted hence situates the researcher even further as a vital contributor towards the shaping of data and consequently study outcomes. Negotiating the complexities of these dynamic relationships has been a key concern throughout this study.

Positionality in particular was shown to play a crucial role in accessing participants during data collection.⁴⁰ For example, there were several instances where potential participants stated that they felt more comfortable being interviewed by someone who shared a common ancestral identity, in this case, Andean. This was because it was assumed that having an association with the Andean identity would make someone more sensitive to the experiences of being a member of a marginalized population. It was also possible that being a young female researcher who was not an employee of the government (i.e., neither a health professional nor a municipal government worker) may have been less threatening to some individuals leading them to feel more open to discussing sensitive issues. In this regard, there were many instances where participants said negative things about specific public service individuals which they stated they likely would not have said to anybody else out of fear of these individuals finding out. As such, being aware of these issues positively influenced gaining access to participants and the type of information they felt free to discuss. Accordingly, this also raised ethical concerns in terms of confidentiality as will be discussed in Section 4.10 of this chapter.

Asserting a reflexive stance during each stage of this investigation aided in establishing the position of the researcher and thus how the data and subsequent analysis and dissemination were approached. As such, issues pertaining to assumptions and perceptions of identity, including the ways in which varying identifying markers and categories are constructed in specific research settings and the impact these can have on either facilitating or impeding access to data have been discussed within this section. How these issues were overcome and the strategies employed to counterbalance such

⁴⁰ Data collection is discussed in more detail in section 4.8 of this chapter.

matters will be defined in greater detail throughout the remainder of this chapter as detailed by the specific methods used for fieldwork, data collection and analysis.

4.5 Preparing for Fieldwork and Arrival

Fieldwork for this study was carried out between November 2011 and March 2012. Formal preparation for fieldwork began with the development of the research design and proposal. This involved conducting preliminary literature searches for the topic of this study. During the design stage it became clear that a number of practical considerations needed to be defined prior to departure in order to ensure successful data collection once in the field. These included determining the general geographic region where this study would be based, establishing contacts in the chosen communities so as to facilitate access to participants in rural areas, and deciding on an appropriate timeframe for fieldwork and data collection.

As a starting point for determining the geographic area of the study and establishing contacts, a database of NGOs and other advocacy organizations working in community health, (specifically maternal health) in Peru was compiled. The organizations included in this list were located through Google internet searches and subsequently input into an excel spreadsheet. This collated list provided a means to identify and contact key members of these organizations and was later used as a reference during the initial stages of sampling and selection of the research site. Organizations which worked both with CHWs and maternal health were contacted via email with requests to participate in their projects as a volunteer in exchange for facilitated entry and access to their work sites to collect data for this investigation. By June 2011, invitations from two NGOs working in the Cusco region of Peru were received accepting requests for participation.⁴¹ These NGOs were initially included in the database and therefore selected as potential contacts due to the strong focus they exhibited in activities geared towards promoting and improving maternal health through community based approaches, specifically through the use of community health workers. Further, having prior familiarity with this

⁴¹ The names of the NGOs have been omitted to protect participant confidentiality.

particular region of the country, this location was considered to be an appropriate setting to begin data collection. The months of November to March were then decided as the data collection period. This timeframe was chosen in order to ensure a sufficient amount of time both in the field as well as upon return from fieldwork for continued data analysis and the ensuing reporting of findings.

An intensive Quechua language course was undertaken upon arrival in Cusco in order to facilitate travel into the rural communities through having a basic understanding of the local language. During the initial arrival period, meetings with the heads of the two NGOs were carried out where a schedule was established indicating potential data collection days. Entry was thus gained into otherwise hard to reach rural areas by accompanying the NGO teams on pre-established community health days. Participating in these activities further facilitated access to study participants and served as a starting point towards the selection of the case study site as well as for the sampling and recruitment techniques employed in this study as will be described in Section 4.7.

4.6 Selecting the Case

In utilizing an integrated case study and grounded theory design, the first step of data collection usually requires defining the unit of analysis and the boundaries of the case in question (Andrade 2009). As case studies offer a systematic way to examine a delimited instance of a particular social phenomenon, while grounded theory is used to interpret the social processes which occur through theoretical abstractions generated from the data, identifying the specific case and type of case study to be conducted was a necessary precursor to the selection and recruitment of participants for this study, and thus data collection and subsequent analysis⁴² (Baxter and Jack 2008).

⁴² It is important to note that in following the tenets of a grounded theory study, data collection and analysis were conducted simultaneously, with analysis commencing immediately following the first interview and continued until theoretical saturation was reached. This is discussed in more detail throughout the remainder of this chapter.

The “case” in a case study, as Miles and Huberman (1994, p.25) describe, refers to “...a phenomenon of some sort occurring in a bounded context”. Using a graphic representation, they liken the case study to a circle with a heart in its center. The focus of the study is the heart, while the circle, with a somewhat unfixed boundary defines the limits of the case that is to be studied, and correspondingly what is not to be studied (Figure 7). The type of case study used equally guides how the case is defined and what is to be investigated depending on the overall study purpose (Baxter and Jack 2008).

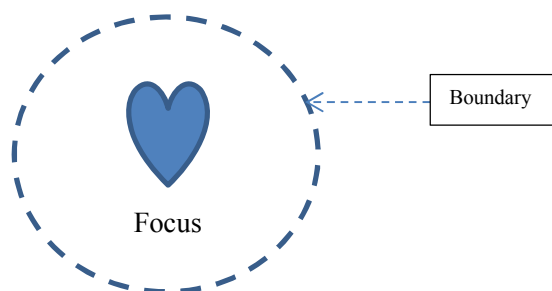


Figure 11: Graphic representation of the case as the unit of analysis

As stated in section 4.3.3, this study adopts an intrinsic case study design directed towards developing in-depth descriptions of the social processes occurring within the bounded case, or unit of analysis. Accordingly, a holistic single case study with embedded sub-units is employed as the specific case study design, where the focus of the case consists of exploring the experiences and views of individuals and groups invested in improving maternal health services in rural indigenous communities of the Andes.⁴³ Within this focus lies the explicit aim to understand whether and in what ways the ethnic identities of the participants, in particular those of the indigenous CHWs, may be utilized or negotiated as a way to facilitate interaction between community members

⁴³ A holistic single case study with embedded sub-units was chosen over a multiple-case study design. Multiple case studies are used to examine several cases within and across varied study settings where the context of each may be different. A holistic case study with embedded units on the other hand allows the researcher to explicitly focus on a single case where the overall context of the study setting is congruent to the focus of the study (Baxter and Jack 2008; Miles and Huberman 1994). The choice to use a holistic single case study was adopted primarily for reasons of practicality and time constraints to the data collection period, as multiple case studies, though considered advantageous, can often be time consuming and costly (Baxter and Jack 2008).

as service users and other actors involved in the provision or delivery of maternal health services to the communities. The embedded sub-units of the case are correspondingly categorized in terms of the field of work specific to each of the groups of stakeholders, namely: *community members, community health workers, NGO workers, health professionals, and government officials*. In this way, these five participant types provide a means to understand the complex social processes occurring in the case based on the varied experiences of participants both within and between each type of participant group.

The boundaries and sub-units of the case in this study are therefore defined by the geographic location of the study site, the population of individuals and groups involved with both maternal health services and the CHW programs operating in the area as well as the temporal duration of the specified data collection period. As such, the geographic boundary specifically refers to communities served by the two NGOs that facilitated access. These were all located in the Peruvian Province of Calca (Figure 12), located in Cusco's Sacred Valley of the Incas (Figure 13).



Figure 12: Map of Calca Province

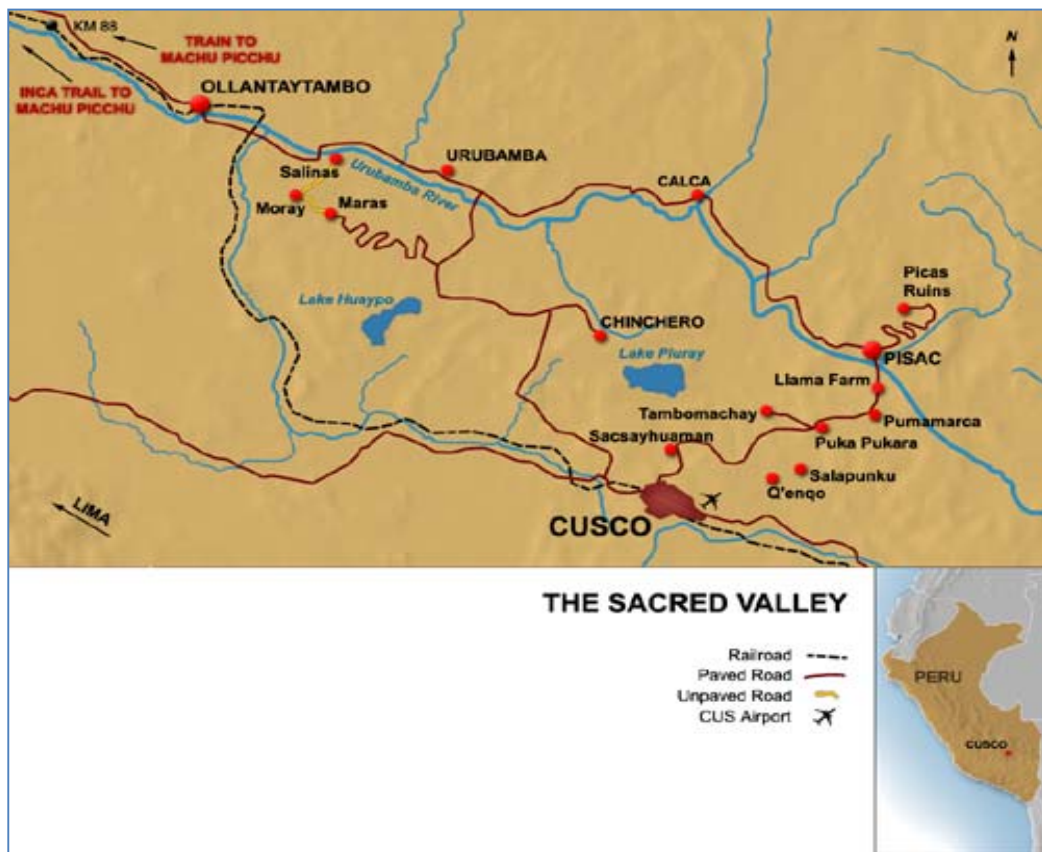


Figure 13: Map of the Sacred Valley of the Incas (All About Peru Travel 2010)

The population boundary consists of individuals and groups invested in improving maternal health services in the specific context of their involvement with the CHW program operating in the area. The particular CHW program in this regard consists of CHWs jointly governed and coordinated by Peru's decentralized municipal governments, district level health facilities, local NGOs and the community members themselves. Accordingly, these have formed the basis for the categorization of the embedded sub-units of the case as described above. Finally, the temporal boundary confining the unit of analysis refers to the allocated four month period of fieldwork including data collection and the initial concurrent stages of data analysis Figure 10 provides a visual representation of the units and boundaries making up the case.

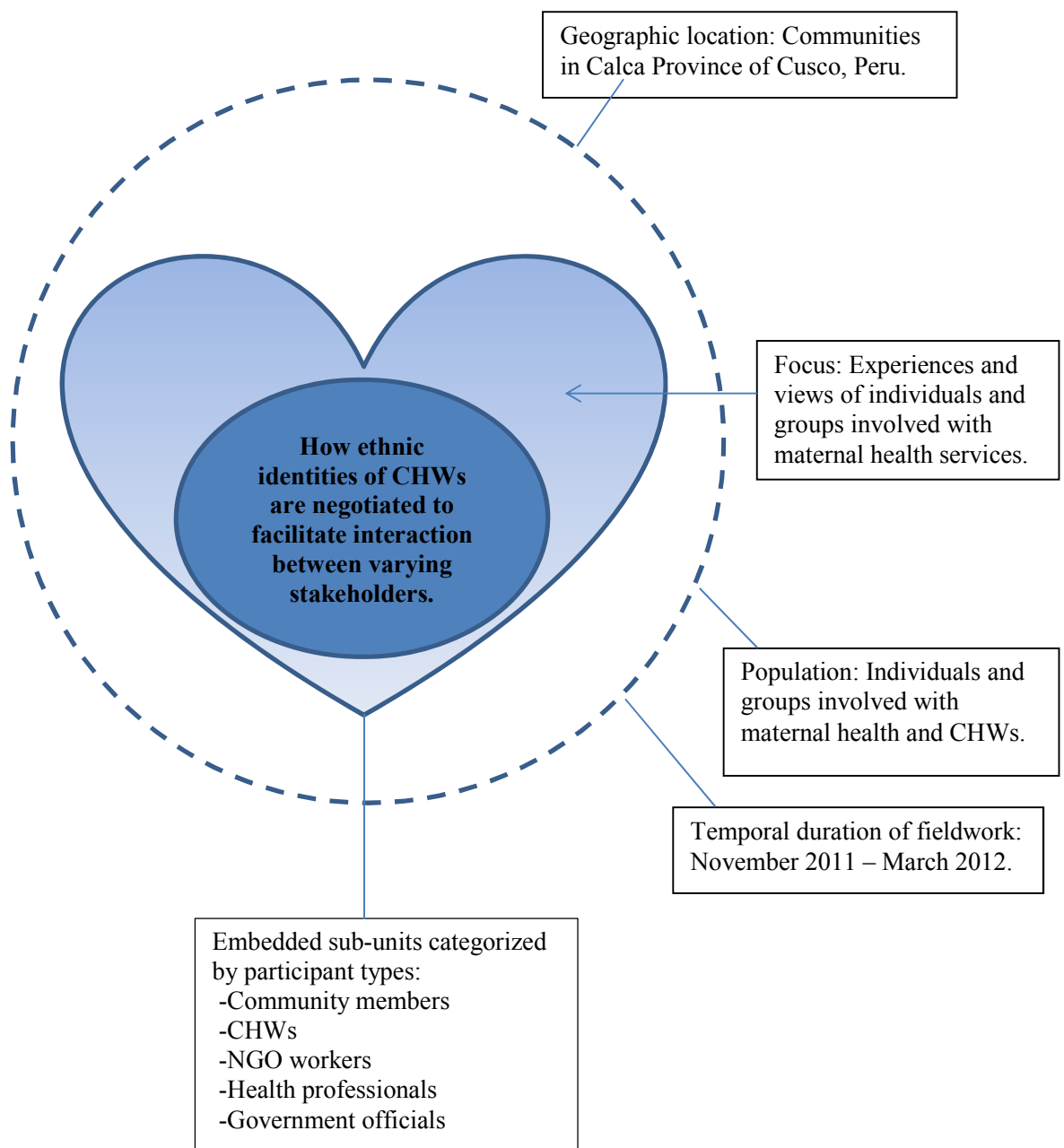


Figure 14: Boundaries and units of the case study

4.7 Selection, Recruitment and Eligibility Criteria for Participants

Participants for this study were located and selected using non-probability sampling techniques. In contrast to probability or random sampling methods which are more often associated with quantitative studies, non-probability sampling in qualitative research generally involves smaller numbers of participants selected on the basis of their involvement in the specific social processes or social phenomena under investigation (Miles and Huberman 1994). The exact number of participants and data sources included in qualitative studies is thus commonly unknown at the start of data collection. Once fieldwork begins however, the sample becomes more specified and is accordingly dependent on the methodology and sampling techniques used. As this study employs a combined grounded theory and case study design, the sampling techniques applied were progressively theory driven. That is, participants were initially sampled based on basic eligibility criteria, such as their involvement with the study context, and subsequently as data collection progressed, on their ability to contribute to the theory constructed from data collected within the boundaries of the case. As such, a combination of purposive, snowball and theoretical sampling methods were used to determine the selection and recruitment of eligible participants for this study.

4.7.1 Eligibility Criteria

A specific set of basic eligibility criteria was first established. To be considered for inclusion in this study, participants were required to be aged 18 or over. In the case of Andean women and their immediate family members who were selected on the basis of needing or seeking maternal health services, including through the use of CHWs, the time period of childbirth or end of pregnancy was also factored into the eligibility criteria.⁴⁴ Women in this participant group who were pregnant during the time of the study were eligible to participate, however women who had reached the end of pregnancy could only participate if at least six months had passed between the end of

⁴⁴ Women who had reached the end of their pregnancy with an unsuccessful pregnancy outcome (e.g., miscarriage) were also considered eligible to participate in this study.

pregnancy and participation in the study. This specified time was maintained in order to minimize the risk of imposition to women and their families during the postpartum or post pregnancy adjustment period. Accordingly, as maternal health care by virtue of its definition includes care provided to pregnant women and infants younger than six months, women in this group were more likely to report on their experiences with services rendered prior to the start of the data collection period (i.e., care sought or received during pregnancy up to the first six months following childbirth). A time period of up to two years following the end of pregnancy was established as additional criteria in order to minimize potential memory bias in the case of participants recounting past events. Relevant family members, such as husbands or partners were eligible to participate in this study if they were present with the women during the seeking or utilization of maternal health services. All other members of the study population were eligible to participate as long as they met the specified age requirement and had direct involvement with maternal health services and CHWs at any point during the time of the study period.

4.7.2 Sampling Methods

Purposive sampling, also known as purposeful or judgment sampling was used to direct the initial stages of data collection. Purposive sampling is a sampling method where the researcher selects a sample based on a specific pre-defined purpose, usually with the aim to locate sources of information that would be the most productive in addressing issues pertinent to the research problem (Marshall 1996). For this investigation, this was accomplished by first defining the unit of analysis and general boundaries of the study as represented in Figure 14, and then determining which potential variables, such as the basic eligibility criteria, would likely inform the outcome of the study. Once the geographic and temporal boundaries of the study site were established, a sample of individuals was selected on the basis of their involvement with maternal health services and CHWs. Accordingly, as this study examines the differing experiences of a diverse group of stakeholders (i.e., the five groups of participant types) invested in the same issue (i.e., improving maternal health services for Andean community members), the

purpose of the initial sample was to locate participants and data which were most likely to directly relate to the research focus. In this regard, the purposive sample was at first determined through practical knowledge of the research area as garnered from early literature searches and fieldwork preparation.

The two NGOs contacted prior to the commencement of fieldwork served as the starting point for selecting the initial purposive sample. Accompanying the NGO workers on their field activities facilitated entry and access to Andean communities and provided a means to locate further participants who were also involved with both maternal health and CHWs. At this point, snowball sampling was used to identify additional participants. Snowball sampling, also referred to as chain sampling, is one of sixteen strategies for purposeful sampling as listed by Miles and Huberman (1994). This strategy, as they define, is a form of sampling that is based on a referral system which is advantageous for inductive theory-driven data collection. Blaikie (2000) accordingly describes two related uses for conducting snowball sampling. First, it is beneficial for studies which require locating populations that are difficult to identify. Second, this strategy allows the researcher to find naturally occurring social networks of people (e.g., family, friendship or colleague networks). As Andean communities are often very rural and isolated, snowball sampling was employed to meet both these needs. As such, it provided a way to gain entry into otherwise hard to reach communities, thereby increasing access to information and participants. It also assisted in locating the participants' varying social and professional networks which would have been otherwise difficult to identify. Therefore, with the aid of the two NGOs, the first steps of finding participants and data sources involved visiting Andean communities and attending community meetings. The initial purposive sample was thus made up mainly of the NGO teams and Andean community members attending these meetings, including also a small number of health professionals and municipal government employees who were present at the community meetings. Additional participants were then identified by asking the members of the initial sample if they were familiar with or could suggest other individuals or groups who were also involved with either maternal health or CHWs. In using this approach,

the number and types of participants and data sources grew through this system of referrals and consequently facilitated the identification of other relevant actors living or working in this context in the study area.

As sampling and data collection progressed, theoretical sampling was used to identify sources of information which were likely to contribute to the developing theory.

Theoretical sampling, as Charmaz (2006, p.189) specifies, is the principal sampling strategy used in grounded theory studies in which “...the researcher seeks people, events, or information to illuminate and define the boundaries and relevance of the [theoretical] categories”. The theoretical categories in this instance are developed during the analysis phase of a study and are determined through the identification of common themes and patterns exhibited by the data (Charmaz 2006). As is emphasized in studies using a grounded theory approach, analysis for this investigation was conducted in conjunction with data collection. Through jointly collecting and analyzing data using a system of coding and comparative analytical techniques, as will be discussed in Section 4.11 of this chapter, further sources of information were sought which could examine and elaborate tentative ideas and theoretical concepts developing from the data. Theoretical sampling is in this regard another form of purposeful sampling; however the key difference with this sampling strategy lies in the logic behind the technique (Charmaz 2006). Rather than locating participants on the sole basis of sharing a particular set of characteristics, it is instead geared towards identifying people and information that specifically pertain to conceptual questions and theoretical development (Miles and Huberman 1994).

The initial purposive and snowball sampling techniques thus served as a point of departure towards determining the environment of maternal health services and CHWs providing this care. As such, this starting sample was based mainly on the demographic attributes of the study population. As the complexities of the varying relationships and experiences of the participants living and working in the study context began to emerge, theoretical sampling was used to obtain data which would confirm or disconfirm the conditions of the theoretical concepts comprising the developing theory. For instance,

initial participants as stated, were sought on the basis of their direct involvement with CHWs and maternal health services in Cusco's Andean communities. However, once data analysis commenced and tentative categories were identified based on common themes and patterns reflected in the participants' responses and behaviors, additional participants were sought which could elaborate potential analytic connections between the categories. In this way, the specific processes underlying the relationships and experiences of the relevant stakeholders of this study could be determined. Theoretical sampling thus led to the inclusion of a greater range of participants and materials, such as identifying new settings for participant-observation and document review, as well as focusing and refining interview questions which would more critically examine the developing theoretical concepts and theory. In one occurrence of theoretical sampling for example, sources were sought on the basis of individuals' experiences with discrimination in the workplace, specifically amongst the varying health providers working or receiving training in district level health facilities. In this regard, participants and data sources included in this sample were not selected because of their involvement with or as CHWs or maternal health specifically, but rather were sampled in an effort to develop an understanding of the experiences of different cadres of health providers working in a multi-ethnic and multi-cultural environment where maternal health services are provided (i.e., a district level health facility that caters to both the districts' urban residents as well as Andean community members). Information was thus systematically gathered through a theoretical sample which examined emerging conceptualizations of discrimination as it was experienced between different cadres of health providers including CHWs, as well as between health providers and health seekers in Cusco's district level health facilities.

The samples included in this study were intended to reflect both the empirical characteristics of the study environment and its population, as well as the particular qualities composing the conceptual categories of the developing theory. In this regard, these sampling techniques were utilized to assist in determining the boundaries of the study. The aim therefore was not to locate a study population based on representation or

generalizability, as is more common in quantitative studies, but more so to identify and interpret the complex social processes specific to the study area. Correspondingly, as the logic of grounded theory requires remaining open to the data and maintaining flexibility in terms of the geographic location or availability of potential data leads, the exact boundaries, and thus number and types of data sources were not distinguished until the final stages of data collection and analysis. This is discussed in more detail throughout the remainder of this chapter.

4.7.3 Participant Recruitment

Participant recruitment was conducted on the basis of decisions made during the sampling process and therefore began in conjunction with the start of fieldwork. Once in the field and in accordance with the initial purposive sample, selected individuals and groups involved with CHWs and maternal health services that were living or working in the study area at the time of fieldwork were considered potential participants for this study and extended invitations to participate. To increase accessibility to the study population and therefore ensure a sufficient amount of data would be collected, potential participants were approached through multiple channels, with requests made both verbally and in writing. This included extending invitations in person, by telephone or email, and through referrals from other participants. In addition, a Spanish language information sheet detailing the study plan was distributed to potential participants (Appendix 7).

Participants from Andean communities, including CHWs, were mainly recruited through both formal verbal requests presented to the community members during community meetings, and also through individual in person requests made during community visits. In the case of requests presented during community meetings, community members were notified of the intentions and purpose of the study as well as the days in which further community visits were to occur. In this way, potential participants from the community member groups were aware of the opportunity to participate in this study and when they would be able to do so if interested. The majority of CHWs included in

this study who were not recruited during community visits were approached during the CHW training sessions held in the district villages. Potential participants from this group were thus also presented with verbal invitations during these sessions. As NGO workers, health professionals and municipal government employees generally have greater access to technological or written forms of communication; potential participants from these latter three groups who were not primarily contacted in person were contacted by telephone or email. Potential participants identified on the basis of referrals acquired during snowball sampling as well as participants selected from the theoretical sample were approached utilizing all of these means, as was appropriate for each given individual.

Out of the sampled study population, a total of twenty-six recruited participants were selected for interviews as will be discussed in section 4.8.1. The actual number of participants included in this study however is much higher. Participants, in this regard do not just refer to those who were interviewed but also to all individuals of the study population which were present during participant-observation and who met the basic eligibility requirements. This also included for example, participants that were located and recruited during community visits. Additionally, as analysis and theoretical sampling progressed, many of the participants were contacted and visited on multiple occasions in order to gather further data based on the developing theoretical themes.⁴⁵

4.8 Data Collection

The process of collecting data in qualitative research primarily begins in the field and involves a series of corresponding activities directed toward gathering in-depth information pertaining to the research problem (Creswell 1998). Creswell (1998) refers to these activities as a “data collection circle”. That is, a circle of activities which can be entered at any point, consisting of locating a study site or individual, gaining access and building rapport at the site or with study participants, sampling purposefully, collecting data, recording collected information, exploring and resolving field issues such as

⁴⁵ Re-visiting participants to gain further information is a substantial part of the grounded theory process.

negotiating issues of access or ethical concerns, and managing and storing data once it is collected. These activities all constitute important interrelated steps in the data collection process, and as such are influenced by the specific data collection methods employed during fieldwork. Once a study site and population are located for example, the researcher needs to assess the most appropriate ways to approach and gather data so as to ensure the collection of rich insightful information that is less likely to be compromised by potentially difficult field issues (Creswell 1998). Accordingly, the methods used throughout the data collection process are further guided by the methodological framework underlying the research design.

In grounded theory studies, the methods used to conduct these activities are regularly shaped and reshaped, subsequently refining collected data (Charmaz 2006). Grounded theory methods in particular permit flexibility to follow leads as they arise, thereby allowing the researcher to gain a clearer focus of the data and thus the processes underlying what is being studied. In this regard, as Charmaz (2006) proposes, data collection methods are methodological tools utilized to enhance knowledge into studied life and consequently make sense of data. They are not as such intended to provide automatic insight, but rather are used to provide guidelines with which to direct data collection. Following the guidelines offered by Charmaz (2006), data for this study was collected using a combination of semi-structured interviews, participant-observation, and document review which are outlined in the following subsections.

4.8.1 Interviews

A total of twenty-six semi-structured interviews were conducted while in the field.⁴⁶ Interview participants consisted of individuals who were either potential maternal health service seekers, maternal health service providers, including CHWs and coordinators of

⁴⁶ It is recognized that qualitative studies of this length generally include a larger interview sample, however given certain limitations in participant accessibility which will be described in section 4.9 of this chapter, this study was only able to recruit 26 participants. Given the nature of grounded theory however, sufficient data was collected to reach theoretical saturation as will be described in section 4.11.2 of this chapter.

health and social development programs in Cusco's Andean communities. Specifically, there were four community members (consisting of three community women and the husband of a community woman), six CHWs,⁴⁷ four NGO workers, nine health professionals (consisting of two community nurses, one health center nurse, three medical doctors and three obstetricians) and three municipal government workers (Table 3 and Appendix 10).

Participant Groups		Female	Male	Total
Community Members	Pregnant Women	3		3
	Husband	1		1
Community Members as CHWs	CHWs	4	2	6
NGO Sector	NGO Workers	3	1	4
Health Professionals	Community/Technical Nurses	2		2
	Health Center Nurse	1		1
	Obstetrician	3		3
	Medical Doctor		3	3
Government Coordinators of Health and Social Development Programs	Municipal Workers	3		3
Total		20	6	26

Table 3: Interview participants

Interviews were both digitally recorded and recorded in field notes, and ranged from approximately fifteen minutes to one hour in length.⁴⁸ Of these, there were twenty-three individual interviews and one group interview consisting of three community health workers, for a total of twenty-four interviews and twenty-six interview participants.

⁴⁷ Although only 6 CHWs were formally interviewed, additional data was collected from an estimated 30 to 40 CHWs during participant-observation. As this thesis focuses on the role of CHWs from the perspectives of each of the different participant groups (including the CHWs themselves), it was felt that sufficient data was collected to develop an understanding of each groups experiences with CHWs. This is discussed in more detail in the next section as well as Section 5.2.2 of the following chapter.

⁴⁸ Section 4.9 discusses some limitations of using unrecorded interviews and how these were overcome.

Interviews with community members were conducted in the community member's home. Interviews with CHWs were generally conducted in Calca Province's main town or just outside of the health post, as these were usually the location of CHW training sessions as discussed in the next section. Interviews with health professionals, NGO workers and municipal government employees were generally conducted in their respective offices at their place of employment.

Prior to each interview, the participants read (or were read to if unable to read) a detailed Spanish language consent form including background information of the study (Appendix 4). Background information of each of the interview participants was then collected guided by a participant background information checklist (Appendix 8). Information elicited included: name, community, occupation, self-identified ethnic affiliation, age range, level of education, relationship status, children, number of pregnancies and breastfeeding status if applicable. This background information was included in order to gain a more comprehensive understanding of the context and personal experiences of the participants. Following consent and gathering of background information, the interviews were conducted using a semi-structured interview guide catered to each of the participant groups (Appendix 9). The questions began as open ended and general and were aimed to learn about the participants' views, experiences and behaviors while seeking, delivering or coordinating maternal health services. The interviews helped to uncover how the relationships between each of the participant types influenced health seeking behaviors and the ways services were carried out. Probes were then used to elicit further information when interesting or consistent themes were identified (Appendix 13).

4.8.2 Participant-Observation

Participant-observation was used to supplement data collected from interviews. This method of data collection is useful in that it can allow for a more holistic understanding of the research environment as well as allowing further insight into the daily lives of the research participants. Participating in the day-to-day activities of the participants and

closely observing their encounters and interactions with other people facilitated gaining a unique insight into the social world of each actor from their own point of view.

Participant-observation activities consisted of visiting fourteen rural communities and socializing with community members when possible as well as accompanying them on medical appointments or meetings. Rural communities were visited approximately three to four days of each week during the fieldwork period. Additionally, a total of four CHW training sessions and six community meetings were attended. The CHW training sessions were each coordinated jointly by the local municipal governments and the designated health post of each community where the CHWs worked, as well as the specific NGOs working in these locales. Community meetings were coordinated by the president of each community and members of the municipal government and employees of the health posts were generally expected to attend. The NGOs also coordinated eight separate community health days where a mobile clinic was set up in eight different communities. The mobile clinics consisted of a team of medical doctors, obstetricians, nurses and NGO employees. Table 4 provides a list of the communities visited during participant-observation).⁴⁹ Other locales which were visited frequently included the town's regional health center, three health posts, six rural health posts and two maternal waiting homes. A standardized checklist was used during all community visits in order systematically record observations of the activities or interactions occurring (Appendix 11).

⁴⁹ The organization and content of the CHW training sessions and community meetings are discussed in more detail in section 5.2 of the following chapter.

CHW Training Session	Community Meeting	Mobile Health Clinic
Town 1 (Jan 12)	Community 2 (Nov 2011)	Community 7 (Dec 2011)
Community 1 (Jan 2012)	Community 3 (Nov 2011)	Community 8 (Dec 2011)
Community 1 (Feb 2012)	Community 4 (Dec 2011)	Community 9 (Jan 2012)
Town 1 (Feb 12)	Community 5 (Dec 2011)	Community 10 (March 2012)
	Community 6 (Dec 2011)	Community 11 (Mar 2012)
	Community 1 (Dec 2011)	Community 12 (Mar 2012)
		Community 13 (Mar 2012)
		Community 14 (March 2012)

Table 4: List of community visits

4.8.3 Document Review

A number of technical reports and documents were also collected during the fieldwork period for this study. These documents came from a variety of sources in both the public and private sectors, such as Cusco's regional Ministry of Health office (DIRESA Cusco) as well as some of the NGOs working in the study region. Technical reports were also collected from NGOs and other Civil Society Organizations based out of Lima, Peru's capital. Of the documents and reports obtained from NGOs, some were freely available to the public while others were only available through personal requests made by the investigator. A number of documents and reports listing anonymized patient information such as requests for vertical or horizontal birthing were also obtained from the regional

health center. Records from the health center were reviewed on site due to limited availability of copies.

While all qualitative research generally includes some form of document review or textual analysis as background research, particularly in regards to compiling the literature review, this study utilizes a collection of the above listed extant texts as supplementary sources of data. Extant texts, such as public records, medical charts, policy documents and government reports are often created not only to relay information targeted towards a specific audience but also sometimes to fulfill certain administrative or official responsibilities. Further, texts constructed for distinct purposes are done so within the specific social, political or situational contexts within which the authors and intended audience operate from. Hospital staff completing medical charts for example, may limit the information recorded depending on whether they are due for an external audit. In the same way, a government document outlining a planned social development program may be written in a manner that is geared toward catching the attention of specific funders. Thus, information from these sources may not always be representative of objective facts or portray the occurring event in its entirety. Analyzing data from these sources can however complement other qualitative data collection techniques. On this basis, document review was conducted to help develop interview questions and probes and to garner a more holistic understanding of the social context of the research setting.

4.9 Data Collection Limitations

A number of limitations impeded the accessibility and recruitment of participants. A considerable limitation concerned language barriers. Language limitations were most prevalent in regards to accessing participants from the community level, in particular community women. This is mainly because in the study region, it is more common for community men to have a higher level of Spanish than women. The community women who were interviewed had a basic knowledge of Spanish. Interviews conducted with the community women were thus facilitated through a Quechua interpreter (who was also a

community nurse) who was present during the community visits. The use of an interpreter also raised certain challenges however. Firstly, there was the possibility that information would be misinterpreted during verbal translations. This was dealt with by focusing on the participant's body language and also continuously reaffirming with both the participant and interpreter to clarify what they meant and also reiterating what was said to ensure correct understanding. Secondly, there was an added potential for receiving biased information given that the interpreter was also already known to the participants as a community nurse who conducted regular visits to their communities. For example, bias could have resulted from community members potentially feeling self-conscious or worried about saying anything negative to a health professional, fearing this information might be spread to other health professionals and that they might get treated poorly in return. Equally, there may have been the possibility that the community nurse would not be objective or react defensively if something negative was said about her or her colleagues. While it would have been preferable to recruit an interpreter who was not affiliated with the communities in any way, this was not feasible due to financial limitations. These issues were taken into consideration during data collection and analysis and reflected on throughout this study in order to reduce as much bias as possible. Despite language limitations with community women, this was not an issue for health professionals, NGO workers or municipal government employees, as the majority of individuals working in these roles in the study region are native Spanish speakers. Community health workers are also usually required to have a fluent level of Spanish prior to taking on the role. As such this limitation did not present itself during interactions with CHWs.

Another considerable limitation was due to geographic barriers. Many of the communities in and around Cusco are at extremely high altitudes and only accessible by car. As a lone female researcher, it was not always feasible to visit geographically distant areas. This represented a limitation towards accessing participants in extremely rural locations, who given such geographic isolation likely experience exacerbated cases of exclusion from health and other social services. Due to the lack of public

transportation to extremely rural areas, community visits could only occur during pre-scheduled mobile health days coordinated by the NGOs, health centers and municipal government employees. As these days were often very busy with community members seeking medical care, many of the community members had to spend hours waiting their turn to visit with the mobile clinic teams. This made it difficult to conduct interviews with community members because it would have been inconvenient for them and unethical as a researcher to ask them to leave their place in line in order to have privacy and ensure confidentiality. However, it was during these visits that the majority of the informal conversations took place which contributed significantly to the data. Nevertheless, as a result of accessibility limitations, it was often difficult to recruit participants for interviews. This was dealt with however by analyzing the data that was collected as closely as possible until sufficient theoretical saturation was achieved.

An additional unforeseen limitation was encountered early into the data collection process. It was noted that many participants felt uncomfortable being recorded and were thus unwilling to participate in interviews unless these were unrecorded. As a result, nine of the twenty-six interviews were unrecorded. Though unrecorded interviews may result in losing some of the nuances of the data due to extensive note taking by the researcher, the decision to include these interviews was however made in order to gain as much information as possible. To overcome potential loss of data, field notes of unrecorded interviews were transcribed and analyzed immediately following the interview. As grounded theory generally involves continuous analysis during data collection (as will be described fully in Section 4.11), unrecorded interviews were not considered separately from recorded interviews as both consisted of detailed note-taking, immediate transcription and analysis of the data. As such, this was not viewed as a major limitation and was dealt with accordingly.

4.10 Ethical Considerations

Ethical approval for this project was granted by Queen Margaret University in September 2011, two months prior to the start of data collection. This study has also

complied with all ethical guidelines as indicated in Law 27815, the code of ethics published by the Peruvian National Institute of Health, a subsidiary of the Peruvian Ministry of Health (Instituto Nacional de Salud 2005). Given the vulnerability of many of the participants, special attention was given to obtaining informed consent and ensuring safe and proper data management in order to protect confidential information.

4.10.1 Informed Consent

Informed consent was obtained from all participants of this study either verbally or in writing. In regards to interview participants, each individual interviewee was given a consent form detailing the aims and purpose of this study prior to the start of each interview. Additionally, a detailed verbal description was read to the participants in Spanish by the researcher at the start of each interview. Given writing limitations, most informants gave consent verbally; however those which were able to provide a signature did so. All participants and informants were notified of their right to decline participation or withdraw from the study at any stage without the need to provide an explanation. Assurance of their anonymity and confidentiality was explained and guaranteed both before and after each interview. Further, as some of the issues discussed during the interview process may have been of a sensitive nature, participants were provided with contact details of an external network of support that they could approach at any time if needed. For example, one potential risk that was considered was whether participants would experience psychological stress from some of the discussions raised. As this study focuses on sensitive topics such as discrimination, pregnancy and reproductive health it was important to be conscious of how to raise such issues during interviews and discussions in a way that didn't harm the participants. This was managed by verbally assuring the participants that they were under no obligation to answer questions that they didn't feel comfortable with and that they could discontinue their participation at any time.

In the case of data collected during participant-observation, consent was obtained from as many members of the study population as possible. Given the complex nature of

obtaining informed consent from all individuals observed during participant-observation, particularly in busy environments (such as health clinics) where multiple people may enter and exit the observation site at any given time, extra care was taken to obtain permission from key participants. As such, key participants included administrative and managerial staff at NGOs and health clinics, the nurses that were being shadowed, community members who were being visited by the CHWs at the time of interview and employees and patients of health facilities. Where it was not possible to obtain permission from individuals who were observed in each site, a visual assessment of each scenario observed was conducted to determine whether there may be any risk to any of the participants in using this data.

4.10.2 Data Management: Storage and Transcription

Data for this investigation consists of both recorded and unrecorded interviews, field notes, and collected text based documents. Recorded interviews were taken using a personal digital recording device. Following each interview, the digital file was immediately backed up onto an external hard drive for storage and subsequent transcription and analysis. Handwritten notes taken during unrecorded interviews were also promptly transcribed using Microsoft Word and these were then uploaded onto the same external hard drive for storage and analysis. Extensive field notes were compiled throughout the data collection process and kept in handwritten notebooks. These were later likewise transcribed onto Microsoft Word documents and stored onto the external hard drive. Personal information was omitted from all interview recordings, transcriptions, and field notes. All participants included in this study were assigned a confidential identifying marker and are referred to in all collected data using only this marker.

Following submission of this thesis, all raw data including taped recordings, hard copies of notes and collected documents will be stored and retained in the Queen Margaret University Repository for a period of five years after the research program is completed. Signed consent forms will also be stored at Queen Margaret University, but kept

separately within the Institute for International Health and Development office for a period of twelve months. Following this initial twelve month period, consent forms will be kept in the possession of the researcher for the remainder of the required duration of retention of physical data as per the Research Ethics Guidelines of the university (Section 1, paragraph 2.4.2).

4.11 Data Analysis Techniques

Data was analyzed using the techniques specified in Charmaz' (2006) practical guide to constructing grounded theory. This was approached using six concurrent stages of analysis. The first stage of analysis was transcription of interviews, participant-observation and field notes as detailed above. The following five stages of analysis were also conducted simultaneously throughout the research process and consisted of 1) initial coding, 2) focused coding, 3) theoretical coding, 4) memo-writing and 5) category building. Codes, memos and categories were developed through the use of the constant comparative method as will be discussed in the following subsection. As described in the preceding section, initial transcriptions of interviews and field notes, followed by coding and memo-writing were conducted while still in the field and kept in Microsoft Word documents and handwritten notes. Upon return from fieldwork, these were imported into NVivo Software for further analysis. NVivo has been used throughout the post-fieldwork analysis phase and has proven a useful tool for storing, sorting and analyzing the data which was collected.

4.11.1 Coding for Grounded Theory

In practice, each unit of data in a grounded theory study is analyzed by developing a series of codes. "Coding", as Charmaz (2006, p.46) writes, "is the pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you *define* what is happening in the data and begin to grapple with what it means". Grounded theory coding is therefore a central component for developing the ensuing analysis. Generally, it consists of at least two main phases, 1) the initial coding phase which involves either line-by-line or incident-by-incident coding, and 2) a focused

phase where the most significant or frequent codes are used to sort and organize large amounts of data. Theoretical codes are also part of this second phase which then lead to theoretical categories through the use of memo-writing (discussed in Section 4.11.1.3).

The main mechanism used to analyze codes in grounded theory research is the constant comparative method which involves "...a continuous cycling between data collection and data analysis" (Steenhuis and de Bruijn n.d., p.8). This is done to identify analytical distinctions through each phase of analysis. To do so, data is compared with data in order to find similarities and differences. This process ensures that "...the data that is collected next is determined by analysis of the previous data..." (Steenhuis and de Bruijn n.d., p.8). The constant comparative method therefore provided a means to make comparisons between interviews, observations or events occurring at different times or places. In this way, knowledge was gained and compared from several different contexts which facilitated the development of important theoretical insights as will be discussed in the following subsections.

4.11.1.1 Initial Coding

Initial coding, also referred to as "open coding" was conducted following transcription of the first interview and continued throughout the initial analysis phase. The purpose of initial coding is to maintain closeness to the data and "...to see actions in each segment of data rather than applying preexisting categories to the data" (Charmaz 2006, p.47). Initial coding thus allows the researcher to remain open to what the participants might view as problematic. Though the goal is to remain as open as possible to the insights of the data as early approaches to grounded theory emphasize (Glaser 1992a), Charmaz (2006) points out that it is highly unlikely that the researcher will not bring prior experiences or preconceived concepts to the field. It is important therefore to remain open to the data but to also acknowledge that initial coding and the ensuing analysis that is constructed is an interpretation of the experiences of the researcher as well as of the participants. In this sense, initial codes may capture provisional ideas which can then be

renamed to better reflect the participant's point of view following further data collection and analysis.

Initial coding for this study was conducted using both line-by-line and incident-by-incident coding. Line-by-line coding was used mainly during interview analysis. The main purpose of line-by-line coding for this study was to discover the processes or the actions of the events being described by participants. This was done by following Glaser's (1978) advice to code with action statements or gerunds rather than descriptive words. For instance, the code "*feeling like a community authority figure*" derived from the interview line "...the community members know to come to me when there is a problem..." (Community Health Worker 1), reflects how this participant views their role as a CHW. A descriptive code, such as "*community members visiting community health workers*" would do well to describe the situation but could result in missing important meanings hidden in the data, in this case the CHW feeling that the community members know to visit CHWs if they need advice.

Incident-by-incident coding was mainly conducted to analyze data collected from participant-observation. This was done by analytically comparing each incident or observation with previous incidents. For example, an incident observed during one of the CHW training workshops involved several of the CHWs being yelled at by a municipal government worker. The transcription of this incident specified details such as what the argument was about, how the CHWs seemed to react to this and what the final result of the argument was. The code given to this incident was "*being treated disrespectfully*". This code was then compared to other incidents in which participants described similar disrespectful treatment. Sorting incidents under this code and comparing them with each other led to the identification of some nuances occurring within each incident that otherwise may have been missed. For example, observing and coding the interactions of individuals who felt they were being treated disrespectfully led to the development of several focused codes which will be described below.

4.11.1.2 Focused Coding

After the initial codes were compared against each other, they were then sorted into groups of focused codes. “Focused coding”, as Charmaz (2006, p.57) explains, “means using the most frequent earlier codes to sift through large amounts of data... and requires decisions about which initial codes make the most analytical sense to categorize your data incisively and completely”. The process of focused coding thus consisted of analyzing initial codes and developing a more directed conceptual code that synthesizes the initial codes. The above code, *“being treated disrespectfully”*, for instance came up frequently during initial coding. As a result, further analysis of the data leading to this code began to highlight instances where participants seemed to ignore or even accept and expect disrespectful treatment from others. This then led to the development of the focused code: *“taking disrespectful treatment for granted”*. Further development of this focused code then resulted in identifying a basic social problem occurring amongst the individuals in the study site, that of intergroup tensions (as will be discussed in Chapter 6 of this thesis). As such, this focused code made explicit the notion that disrespectful treatment was accepted as a way of life in Andean communities, while this was only implicit in earlier initial codes. Initial codes and focused codes were therefore used in this study to develop analytic interpretations of the statements and observed experiences of the participants. (See Appendix 14 for an example of the analytical coding process).

4.11.1.3 Theoretical Coding, Memo-Writing and Category Building

Theoretical codes are developed from the codes which were selected during focused coding. This form of coding involves conceptualizing how the preceding codes may be integrated into a substantive theory. “These codes”, as Charmaz writes, (2006, p.63), “not only conceptualize how your substantive codes are related, but also move your analytic story in a theoretical direction”. Following this logic, theoretical codes were developed through the process of memo-writing and category building. Memo-writing is the step in the grounded theory process which enables focused codes to be raised to conceptual categories. The process of memo-writing consists of writing informal

analytic notes about the data and labelled codes. This strategy is an important part of constructivist grounded theory, in that the researcher is able to become actively engaged in the data through the writing of new ideas or insights as they are developed. The method of memo-writing used in this study involved the use of “thick description”. A term made popular by American anthropologist, Clifford Geertz, thick description refers to using detailed explanations to explain not only behavior, but more importantly the underlying context of behavior (Geertz 1973). Thick description, for example, “...specifies many details, conceptual structures and meanings, and...is opposed to "thin description" which is a factual account without any interpretation” (The Cultural Studies Reader 2012, p.1). The memos used in analyzing this study’s data therefore aimed to include as much detailed information as possible in order to develop conceptual categories (See Appendix 15 for an example of a memo used in this study).

Writing memos about the focused codes helped to develop a conceptual analysis of what the participants were experiencing. There were a total of thirty-four memos written during the analysis of this study, ranging in length from a single paragraph to the longest at nine single-spaced typewritten pages. Each memo which was written during the analysis of this study was sorted into a set of seven theoretical categories which will be described fully in Chapter 6 of this thesis: 1) *Feeling internal conflict*, 2) *Being influenced by assumptions*, 3) *Adopting a professionalized identity*, 4) *Bargaining ethnic identity*, 5) *Being empowered*, 6) *Negotiating trust* and 7) *Facilitating interactions*. The categories which were developed from the memos expressed common themes and patterns derived from the codes. Consistent with the cyclical nature of the constant comparative method, these categories were also used to revisit the initial and focused codes in order to draw any further conceptual comparisons. This process was then repeated until sufficient theoretical saturation was attained.

4.11.2 Theoretical Saturation and the Identification of the Social Identity Approach as Useful Analytical Framework

Theoretical saturation refers to the point to stop collecting data because the theoretical categories are “saturated”. This occurs when “...gathering fresh data no longer sparks

new theoretical insights, nor reveals new properties of these core theoretical categories” (Charmaz 2006, p.113). It is important to emphasize that grounded theory saturation is not simply finding a repetition of themes. Instead theoretical saturation occurs when there are no new conceptual relationships to be identified. As Glaser (2001, p.191) writes:

Saturation is not seeing the same pattern over and over again. It is the conceptualization of comparisons of these incidents which yield different properties of the pattern, until no new properties of the pattern emerge. This yields the conceptual density that when integrated into hypotheses make up the body of the generated grounded theory with theoretical completeness.

Accordingly, theoretical saturation is the general aim in a grounded theory study, however it is a notion which requires highly critical analysis in order to provide sufficient evidence that it has been reached. For example, as Dey (1999) points out, categories in grounded theory studies are derived from partial and not exhaustive coding. Under this logic, the properties of a category are saturated based on the researcher’s conjecture (Charmaz 2006). In agreeing with Dey’s (1999) argument, the categories which were developed in this study were found sufficiently saturated once there were no new comparisons to be made with the data. This occurred following the process of sorting the various codes and memos into relevant theoretical categories, some of which overlapped (Appendix 16 shows the table of codes pertaining to each theoretical category). As the codes and memos were sorted into theoretical categories, a number of common patterns concerning how participants perceived and constructed their social identities were identified. Consequently, the social identity approach was identified as a useful analytical framework to further guide the analysis and development of the substantive theory as will be described below.

4.11.2.1 The Social Identity Approach

The social identity approach (SIA) refers to a family of theories pertaining to the social psychology discipline, namely social identity theory (SIT) and self-categorization theory (SCT). SIT as introduced by Tajfel & Turner (1979) and researched further by

contemporary scholars such as Postmes & Branscombe (2010), Reicher et al. (2010) and Brown (2000) can best be described as a theory that predicts intergroup behaviors based on perceived status differences of different groups.⁵⁰ SCT on the other hand focuses less on intergroup behaviors but correspondingly describes how a person perceives collections of people in a group, also including him or herself within or out with the group (Haslam 1997). Turner et al. (1987) likewise describe SCT as the cognitive processes of self-categorization that inform a person's perceptions of him or herself and others in terms of social groups. These two distinct but closely related theories constituting the SIA are linked by their intrinsic concern with "social identity", or the ways in which people define themselves on the basis of group membership (Reicher et al. 2010). Deriving from the notion that group memberships form a key facet of a person's self-concept or self-identity, the SIA recognizes the ways in which individual and group identities intersect, informing perceptions, attitudes and behaviors, and thus relationships within and between different social groups (Kreindler et al. 2012).

In a country such as Peru that is characterized by its multiethnic and multicultural population, this approach provides a useful tool for understanding how an individual's self-identity and corresponding group identity may or may not influence the ways different social groups (e.g., ethnic or cultural, or rural or urban) perceive themselves and others, and in turn, how they then behave and interact toward members of other social groups. Some scholars have critiqued the SIA for leading to the reification of social categories and perhaps leaving little room for the individual within the groups to determine what the preconceived categories that define groups are (Spears 2015). However, this study draws on the SIA because its emphasis on understanding the social and historical context of intergroup behaviors is believed to outweigh the limitations posed by the above critiques. Given the social inequalities many indigenous Andean

⁵⁰ Hogg et al. (2008, p.641) define a "group" as "two or more people who share a common definition and evaluation of themselves and behave in accordance with such a definition". The types of groups this thesis refers to are based on social identity and include, *inter alia*, cultural, ethnic, socio-economic status and gender groups. Intergroup behavior likewise is defined as "behavior that emphasizes differences between our own group and other groups (Hogg and Vaughan 2008).

women and their families still face, in particular during the maternity period (e.g., difficulty accessing maternal health services), the social identity approach was applied in this study in order to understand how the socio-historical development of individual and group identities contributes to reinforcing social inequalities, such as intergroup discrimination, or as this study emphasizes, exclusion from maternal health services.

4.12 Conclusion

This chapter has detailed the methodology and research design of this study. The focus of this chapter has been to explain how the philosophical assumptions of social constructionism, interpretivism and symbolic interactionism have been used to guide this study. The methodology which was developed was thus based on these assumptions and used a combined form of constructivist grounded theory with case study research. The specific methods of data collection used in this study (i.e., semi-structured interviews, participant-observation and document review) were discussed followed by a description of the data analysis techniques used as consistent with grounded theory. This chapter also examined key methodological concerns such as researcher positionality, data collection limitations, ethical considerations and deciding when sufficient theoretical saturation is attained. Finally, this chapter described how the process of finding a sufficient saturation point while developing a series of theoretical categories resulted in identifying the social identity approach as a useful framework to further guide the analysis. The following chapters present the analysis and discussion of the study findings as guided by the social identity approach and philosophical assumptions of the interpretivist paradigm.

Chapter 5: Andean Identities and the Social Boundaries of Exclusion

5.1 Introduction

The preceding chapters have provided an introduction to the study and detailed its design and implementation. The remaining chapters discuss the findings and analysis resulting from the collected data. The first section of this chapter (5.2) provides a background of the study site and population. Section 5.3 examines Andean identities and explains how these can be understood through the perspective of the social identity approach (SIA). Drawing on the insights of the SIA as introduced in the previous chapter, this chapter explores the ways in which Andean social identities and intergroup relations, as evidenced by the data, may be influenced by the specific social and historical context of the study region. Accordingly, this study draws on the SIA as a starting point while equally drawing on a wider interdisciplinary framework to analyze the study findings. Using examples from the data, this section explains how socio-historical constructs of ethnic and cultural identities in the Andes were interpreted to be an influence on intergroup relations in the study area, in turn contributing to exclusion from Andean health services. Elaborating on some of the concepts of indigenous exclusion as introduced in Chapter 3, Section 5.4 examines six key social barriers, or “boundaries”⁵¹ to maternal health services encountered in this study: *ethnicity, culture, gender, education, language, and institutional*. These were interpreted to be the leading social boundaries indigenous women face when seeking care during the maternity period and were thus labelled “the Social Boundaries of Exclusion”. The final social boundary of exclusion to be discussed, those of institutional boundaries explains how inequality and uneven power relations between the indigenous and non-indigenous populations of the study are often the result of the failure of the state to secure equitable health care for all of the members of the population. Such failures are discussed in terms of weaknesses in culturally adapted maternity policies, recruitment and retention of health professionals

⁵¹ This study uses barriers and boundaries interchangeably. Boundaries are emphasized more however in order to align with the social science concept of boundaries as will be explained in the next chapter.

and finally, the value placed on securing newborn life over that of the mother. The penultimate section (5.5) of this chapter analyzes the relationships between the different participant types, as discussed in Section 4.6 of the previous chapter, (i.e., community members, CHWs, NGO workers, health professionals and municipal government officials), and how these relationships may be influenced by the varying social identities of each group. This is discussed in the context of patient/provider relationships, with particular emphasis on how negative relationships may influence health seeking behavior, thus exacerbating exclusion from health services. Section 5.6 concludes this chapter.

5.2 Background: Study Site and Population

The following two subsections describe the study site and population from which data was collected.

5.2.1 Study Site

Fieldwork for this study was conducted in the highland Peruvian region of Cusco, specifically, in the city of Cusco (the capital), and in rural communities of Calca Province located in the Sacred Valley of the Incas (See maps on pages 55 and 59). Situated at 3,500 meters above sea level and surrounded by the high peaks of the Andes Mountains on each side, Cusco City occupies a status of considerable popularity both within the region and abroad. As discussed in Chapter 3, the Cusco area is home to Machu Picchu and the historical capital of the Inca Empire, and is therefore hugely significant for national and international tourism. The unique characteristics of the study site and its inhabitants – as located in a setting that is in such close proximity to a popular and well-traveled area, while at the same time suffering from extreme neglect and exclusion in the context of health and social services – has formed the basis for defining which specific communities in the Cusco region would be included in this study. The process of determining the final geographic boundaries (and equally the population boundaries), confining the study area to communities in Calca Province, however, was not reached in full until a satisfactory level of theoretical saturation and

therefore completion of fieldwork was achieved. As described in Section 4.6 of the previous chapter, boundaries in a case study are somewhat indeterminate and therefore not entirely fixed. As such, the specific study sites were ultimately determined by the sampling and recruitment outcomes of the study process (detailed in Section 4.7 of the previous chapter). Moreover, in following a grounded theory approach where it is necessary to remain open to the data and therefore flexible to the potentially varying geographic locations and availabilities of study participants, defining the final boundaries of the study in terms of access to participants took equal precedence to selecting the study site based on an intrinsic interest in the distinct social and historical features specific to this area. Thus, the population of the study, as will be discussed throughout this chapter, comprised participants living or working within the geographic boundaries of the study site and was correspondingly defined on the basis of their involvement in the delivery or utilization of maternal health services that were available to *campesinos* in rural communities of Calca during the time of the fieldwork period.

5.2.2 Population

The study population consists of individuals and groups who are invested in the improvement of maternal health services in Calca's *campesino* communities, specifically community members using, seeking or being offered the services of CHWs, community members working as CHWs, and NGO, health, and government professionals that work with or oversee CHW programs. Participants came from five of Calca's eight districts including a total of fourteen *campesino* communities located within the districts.⁵² All of the districts in the study fall under the mandate of the Peruvian Ministry of Health's Regional Health Network of Northern Cusco (*Red de Servicios de Salud Cusco Norte*) (Figure 15). Within the Northern Cusco Network (*Red Cusco Norte*), the communities of the study population are served by two "micro networks" of health services, specifically the Micro Network of Calca (*Micro Red Calca*) (Figure 16) and the Micro Network of Pisac (*Micro Red Pisac*) (Figure 17).

⁵² The five districts and fourteen *campesino* communities included in this study have remained unnamed throughout this thesis and investigation in order to ensure confidentiality of the study participants.

RED DE SERVICIOS DE SALUD CUSCO NORTE

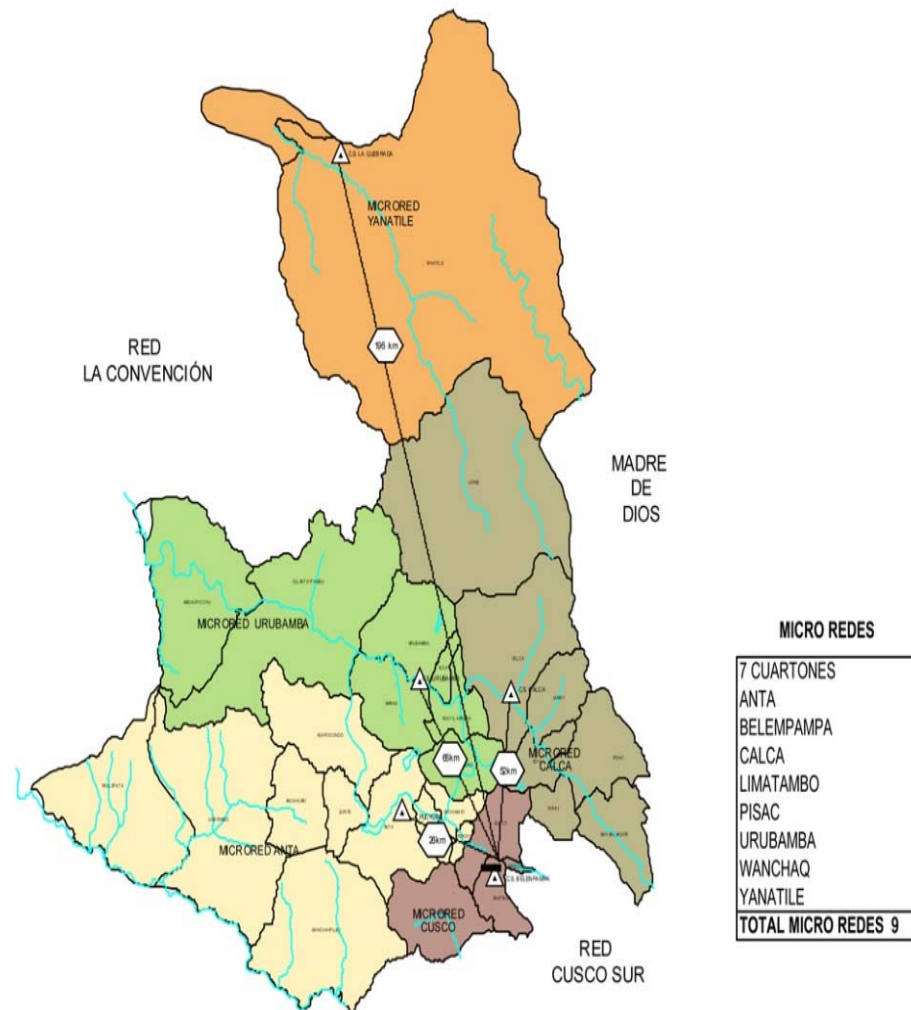


Figure 15: Map of Regional Health Network of Northern Cusco (Gobierno del Peru 2012)

MICRO RED CALCA

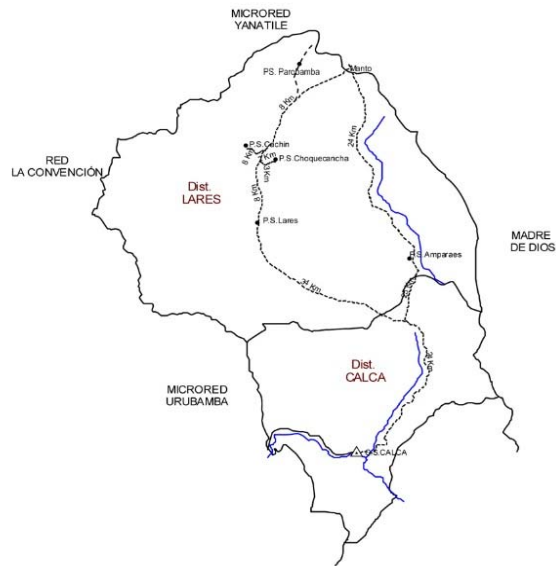


Figure 16: Map of Micro Network of Calca (Gobierno del Peru 2012)

MICRO RED PISAC



Figure 17: Map of Micro Network of Pisac (Gobierno del Peru 2012)

The study population was thus composed of participants living or working within the political and administrative domain of both the district level municipal governments and the regional micro networks of health services. Activities related to maternal health care and therefore CHWs working in this context, are formally governed through both these systems (Dirección General de Promoción de Salud 2011). As mentioned in Chapter 3, Section 3.7.1 and Chapter 4, Section 4.8, the CHWs included in this study form part of a program whose activities are generally jointly coordinated by district level municipal government employees, local health professionals from the province's district level health facilities and rural health posts (see p.72, Figure 9), as well as local NGOs and the community members themselves who take part in the election of their respective communities' CHWs. In consideration of the different groups involved in maternal health services, the study population was broken down into five groups of participants, corresponding to the five sub-units of the case described in Section 4.6 of the previous chapter: *community members*, *CHWs*, *NGO workers*, *health professionals*, and *municipal government officials*.

The *community members* within the study population were individuals living in *campesino* communities inside the boundaries of the study site who have interacted with CHWs or utilized their services in the context of needing or seeking maternal health care. This specifically referred to women and their family members (e.g., partners) who have received or been in contact with maternal health services, including care provided by CHWs during pregnancy or postpartum, or both. The communities composing this group of the study population are extremely isolated and rural, located at altitudes of up to 5,000 meters above sea level and ranging in size from 23 to 210 households per community (Dirección Nacional de Censos y Encuestas 2008). The majority of *campesinos* live in small one or two room adobe houses with dirt floors and roofs made of thatch or tile (Figure 18 and Figure 19).



Figure 18: Adobe houses in rural community



Figure 19: Adobe houses in rural community

Living conditions are very basic with limited access to electricity or running water. Overcrowding within the dwellings is common as many *campesinos* share their living spaces not only with their families but also with a number of animals kept for stockbreeding purposes, such as dogs, guinea pigs and chickens. Consequently, poor hygiene and undernutrition are major contributing factors to occurrences of ill health and thus a dominant public health concern in these areas (Dirección Regional de Salud Cusco 2008). Out of the fourteen communities represented in this study, only four had a local health post, however, at the time of data collection none of these were staffed or in use. As such, excluding periodic pre-arranged visits from health professionals, *campesinos* seeking formal health services are forced to travel long distances, often hiking hours at a time down treacherous unpaved mountain paths, in order to reach the district health posts located in each district's main village. Community members who are not physically able or willing to travel to the district health posts thus either go without care or seek the advice of fellow *campesinos*, traditional healers or CHWs as available in each community (Brown et al. 2006; Dirección Regional de Salud Cusco 2008; Physicians for Human Rights 2007). Figure 20 categorizes such living conditions into general determinants of health and social determinants of health.

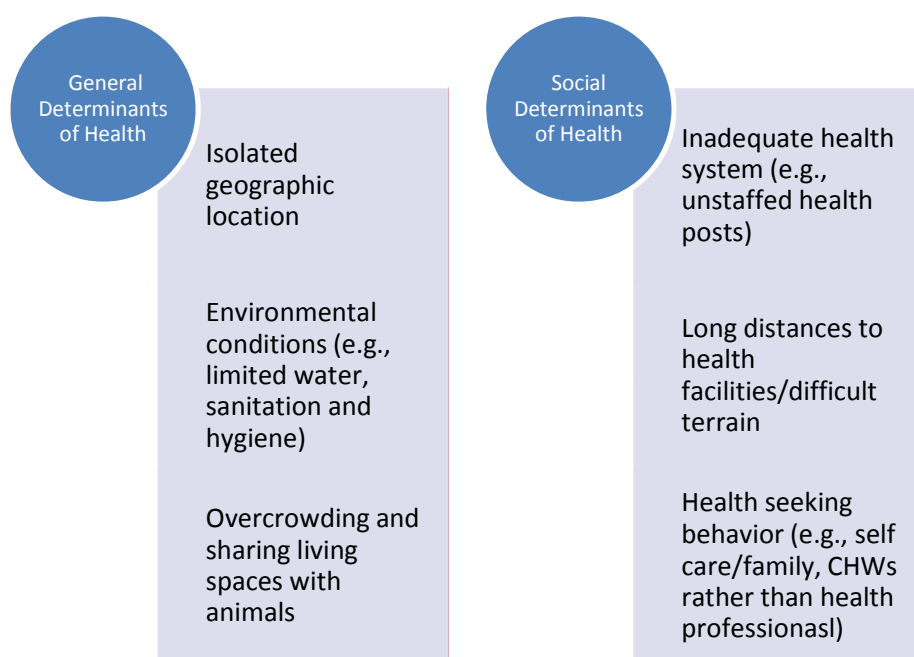


Figure 20: Determinants of health and living conditions in Andean communities

The *CHWs* encountered in this study,⁵³ also referred to as health promoters (*promotore/as de salud*) or community health agents (*agentes comunitarios de salud*), work as voluntary basic primary care providers. Similar to many Latin American countries, the health needs of many communities in the Andes are seldom adequately met by the health system. As such, CHWs have a long history of providing this unmet need, despite a lack of remuneration, in order to ensure survival of their families (Jenkins 2011). In general, CHWs throughout Peru can be either male or female and are usually appointed by their fellow community members through an electoral process. As CHWs, they are responsible for carrying out health promotion, illness prevention, and in some cases, basic curative activities in their communities (Dirección General de Promoción de Salud 2011). In addition to living within the political and administrative authority of the national, provincial and district level governing bodies, rural communities in Calca also have a system of local governance, with each community

⁵³ Six CHWs out of an estimated 30 to 40 – who were not interviewed but were included in data collected from participant observation – were interviewed for this study (See Chapter 4, Section 4.8.1).

presided over by a community elected president and community leaders. Accordingly, all of the CHWs in this study were elected or appointed during recurrent community meetings, or communal assemblies led by each community's president and leaders. Each community represented in this investigation had between one and four CHWs at the time of the fieldwork period. In terms of maternal health care, the expected role of the CHW as mandated by the Ministry of Health is to identify and monitor the number of pregnant women, infants and children under five years of age in their communities and maintain vigilance over their wellbeing (Dirección General de Promoción de Salud 2011). In this context, they should be equipped to keep track of the health status of their fellow community members on the basis of nutrition habits, hygiene, mental health and domestic support as well as to be able to recognize key warning signs of pregnancy complications and ensure that the women are regularly attending their pre and post-natal checkups. They are then responsible for reporting their surveillance findings and care activities to their local community and district level authorities. They are also expected to attend regularly scheduled training and capacitation sessions held in the district village which are coordinated by the district health professionals and government officials, as well as the local NGOs that are involved in these activities. In turn, they are to relay the information they learn back to their communities through both casual interaction with their neighbors and through pre-organized health promotion and education talks.⁵⁴ The CHWs comprising this segment of the study population all worked on a voluntary basis and were thus unpaid.

Many of the *NGOs* operating in the study area have a strong emphasis towards implementing community development initiatives in Cusco's *campesino* communities. Five NGOs were thus included in this study, all of which were involved in community level approaches to improving access to quality health care services for *campesinos*. The activities carried out by the NGO staff in this regard were geared towards managing and training the CHWs working in their project areas, as well as often also taking part in the

⁵⁴ At the time of data collection, such talks were carried out on an ad hoc basis depending on the availability of the community members and CHWs.

selection process of the CHWs through coordination and support of potential candidates. The NGOs working in the study area were both secular and faith based organizations and included local branches of larger international organizations as well as those which have been independently and locally established. The majority of the NGO workers encountered during data collection were Peruvian, many of whom were originally from the Cusco region. Most had at least a working knowledge of the Quechua language, if not native fluency. As private non-profit organizations, their projects were generally developed independent of public institutions, however the NGO staff who were taking part in this study often closely interacted with district level health professionals and government officials in order to enhance CHW activities and community based health care.

The *health professionals* working in the study area consisted of general practice medical doctors, obstetricians and nurses.⁵⁵ As formal education for medical professions is available only in Peru's urban centers, the health professionals included in this study received training and certification in major cities located outside of the study site. All of the health professionals were primarily native Spanish speakers; however some also had varying levels of Quechua fluency.⁵⁶ Employed by the Ministry of Health and placed in facilities (i.e., either district level health centers or rural health posts) within the regional micro networks of health services, the health professionals in this study are considered public sector workers. In terms of community level health services, Ministry of Health guidelines stipulate that the lead doctor in each district's health post is in charge of identifying the necessary components for conducting work with CHWs in the communities under their jurisdiction (Dirección General de Promoción de Salud 2011). This includes keeping track of the number of CHWs working in each community, recording who the leaders are in each of the communities, and maintaining a log of the

⁵⁵ As noted in Chapter 4, Section 4.8.1, of these, two community nurses, one health center nurse, three obstetricians and three medical doctors were interviewed.

⁵⁶ Bilingual ways of speaking have been common in Latin America throughout history. Peru itself is multilingual and in the southern Andes many have varying levels of both Spanish and Quechua depending on the particular level of exposure with each language (Garcia and Otheguy 2014).

general health status and basic demographic information of each of the community members. Further, as health authorities, they are expected to oversee the election process and training activities of the CHWs (Dirección General de Promoción de Salud 2011). Each district health post is also responsible for organizing visits to the communities when possible. This is often coordinated in conjunction with the municipal government and usually includes a small team composed of a doctor, nurse and obstetrician, as well as district level government officials in charge of community development activities.

The *government officials* composing this group of the study population consisted of employees from each district's municipal government.⁵⁷ Social development policies relevant to Cusco's *campesino* communities are administered by specific departments within each municipal government who are mandated by varying ministerial sectors (i.e., Ministries of Health, Education, Women and Vulnerable Populations). Employees of these departments are responsible for coordinating community development programs, and therefore, frequently liaise with community leaders and other community members in the context of implementing these programs. In terms of the CHW program, district level government officials work in partnership with the district health centers and rural health posts, and thus also share the responsibility for overseeing the selection, training and monitoring of the CHWs working in the communities within their jurisdiction. Similar to the health professionals, the government officials encompassing this group of the study population all specified Spanish as their primary language with some also having varying levels Quechua fluency acquired while living in Cusco.

It is important to note that as the boundaries of a case in a case study are to an extent unfixed, there is a degree of overlap between the five groups of participants making up the study population. CHWs, for example, by their definition are also community members and can therefore equally be categorized under both of these groups. Further, some of the NGO workers included in this study were originally trained as medical or

⁵⁷ As noted in Chapter 4, Section 4.8.1, three government officials were interviewed and an estimated 20 were spoken to and observed during participant-observation.

development professionals, and consequently, could also identify with either category of NGO workers, health professionals or government officials. By way of defining the unit of analysis and determining the boundaries of the study population within the case, participants of each group were categorized based on their primary role at the time of data collection. In addition to binding the case based on the geographic location of the study site and the individuals and groups comprising the study population, the temporal duration of the fieldwork period has also served to determine the case and its embedded sub-units. Data collection thus occurred within the specified time period of November 2011 to March 2012 and included participants categorized by each of these identifying markers who were living or working in Calca Province in the context of utilization or provision of maternal health services during this time.

5.3 Understanding Andean Identities through the Social Identity Approach

As described in Chapter 3, Peru has a long history of indigenous exclusion and discrimination. Tensions over ethnic, racial and cultural identities have therefore developed between the different social groups over time and have been interpreted to be indicative of uneven power relations between excluded and non-excluded groups. Accordingly, examining how processes of exclusion might relate to identity development has formed the basis of this study. As stated in Chapter 4, Section 4.11.2, this study draws from the social identity approach (SIA) as a starting point to analyze the study findings. To understand how the social identity approach has been applied to analyze Andean identities, it is first necessary to clarify some of the key elements of the SIA as used in this study. To begin with, “social identity”, as previously defined, stresses the *sociality* of identity constructs. Reicher et al. (2010), for instance, specify at least three ways in which the social foundation of both individual and group identities can inform group dynamics. First, social identity pertains to categorizing the way a person defines him or herself on the basis of similarities and differences with others. Second, perceptions of these categorizations are shared with others and provide the grounding for shared group behavior. Third, the properties associated with any social

identity categorization are products of a collective social and historical experience. Social identity can therefore be an important mechanism for linking the micro-level experiences of social organization to greater macro-level phenomena such as exclusion or uneven power relations produced by shared histories and experiences (Reicher et al. 2010).

As a result of Peru's ethnic and cultural diversity and unique socio-historical development, social identities among different Andean groups are complex and far from homogenous. Corresponding with findings from previous studies, the findings from this study suggest that Andean Peruvians often categorize themselves and others in multiple ways based on ancestry and socio-cultural traits, as well as regional or national affiliation (Canepa 2008; Figueroa and Barrón 2005; Garcia 2005; Paredes 2007; Van den Berghe 1977). This has been evident in this study by the multiple identifying markers used by members of the different groups to identify and classify themselves and others. For instance, kinship, class and regional labels such as *indio* (indian), *indigena* (of indigenous origin), *Quechua* (Quechua speaking), *campesino* (peasant), *comunero/a*, *compañero/a* (community member), *Cusqueño/a* (from Cusco), or even sometimes the Quechua term *Inca wawa* (child of the Inca), were used interchangeably by participants in this study to refer to indigenous Andeans. Labels such as *criollo* (of European origin) and *mestizo* (mixed indigenous and European origin) were also sometimes used to refer to some of the groups who did not identify themselves solely as indigenous Andeans. Alternating between identity labels seemed to occur frequently among the participants of this study, which could be indicative of conscious decision-making by the participants over how to categorize themselves and others depending on the specific social context. For example, as will be discussed throughout this chapter and Chapter 6, many of these identity labels can be used in both a positive and negative manner. As such, alternating between different identity labels could be interpreted to result from weighing which identity label would prove most or least beneficial in any given moment.

The SIA was thus chosen as an analytical starting point because it offers a useful guide for explaining the ways perceptions, attitudes and behaviors leading to exclusion may be

shaped by the social categories individuals place on themselves and others. To examine the process of identity categorization, Kreindler et al. (2012, p.349-350) lists five key dimensions encompassing the SIA:

1. *Social Identity*: People categorize themselves and others as members of an in-group (“us”) or an out-group (“them”), because (a) being part of a positively valued group enhances self-esteem and (b) categorization offers a meaningful way to organize the social world (Tajfel and Turner 1979; Turner et al. 1987). People also compare their group with others, often striving to maximize the positive distinctiveness of their own. When social identity is salient, people focus more on the shared attributes uniting group members than on the personal characteristics differentiating them. These perceptions engender group behavior, which, depending on the context, can be either positive (e.g., cooperation) or negative (e.g., discrimination).
2. *Social Structure*: Structural relations among groups, notably inter-group differences in status and power (especially if seen as unstable and illegitimate), can make the difference between conflict and peaceful coexistence (Tajfel and Turner 1979). Groups can alter structural relations when they take collective action on the basis of their social identity.
3. *Identity Content*: The identities we value are defined by specific norms and attributes. Members internalize group norms and use them to guide behavior (including intergroup behavior) and to evaluate other members, including leaders (Haslam 2004). Members also mobilize in support of, or to combat threats to, these shared norms (Ellemers et al. 1999).
4. *Strength of Identification*: Individuals typically belong to many groups, but tend to identify strongly with some and weakly with others. Group identification amplifies both positive and negative social behavior (Ellemers et al. 2002); high identifiers are more likely to take action in the service of group goals to fight to protect the group from perceived threats to its status distinctiveness, or norms.

5. *Context*: The relative prominence of an individual's multiple identities is not fixed but changes with the social context (Turner et al. 1987). This fluidity of social identity – well demonstrated in empirical studies (Levine and Reicher 1996; Levine and Reicher 1996) – provides hope that by modifying the context, we can change group behavior.

These five dimensions appeared pertinent to the data and were thus used as a starting point for examining the stratification of Peru's various social groups. As such, this provided a way to understand how the different groups within the study area categorize themselves and others and how these categorizations may influence group behaviors (such as discrimination resulting from inequalities or power imbalances). This is particularly relevant to the Cusco region given its unique socio-cultural history as the former capital of the Inca Empire and the subsequent periods of colonial domination, post-colonialism, and the more recent civil war of the 1980s and 1990s (Garcia 2005). The development of the diverse ethnic and cultural makeup of Cusco, resulting from centuries of power struggles can be reflected in the various identity categorizations Andean peoples ascribe to themselves and others. To exemplify this, the CHWs who were interviewed were asked to describe how they identify themselves when speaking to other members of their own stated social group (i.e., other Andean community members or other CHWs). One participant responded as follows:

“...I am from [Community 6] ...I am a comunera [community member] ...when I speak to my fellow community members, they know where I come from and who I am. We are indigena [of indigenous origin] and we are proud...we understand each other...They [non-Indigenous] do not always understand us and we do not always understand them...” (Community Health Worker 4)

The above quote indicates that this participant categorizes herself firstly on the basis of community affiliation, followed by ethnic origin. An interesting characteristic that can be inferred from these types of categorizations is how they correspond to Kreindler et al.'s (2012) first dimension, *Social Identity*, in particular the “us” versus “them” dichotomy popularized in much of the social psychology literature (Kreindler et al. 2012; Tajfel and Turner 1979; Turner et al. 1987). In this quote, this participant

distinguishes between herself as a “community member” (which is interpreted as the in-group, or the “us”) and those who are not a part of this group (the out-group, or “them”). This is further evident by the participant’s reference to “understanding each other” when referring to members of her own social group, or conversely, of not understanding others who are not of the same ethnic background. These categorizations can be useful because they provide a means for the participant to “...meaningfully organize the social world...”, as Kreindler et al. (2012) state in their definition of social identity. At the same time however, the us/them dichotomy can be problematic in that it reflects an interpretation that frames different identity groups as static rather than fluid (Akerlof and Kranton 2000; Moss 2008). Regardless of the complexities of defining group categories, the above quote provides a worthwhile example of how the social identity process can contribute to creating or reinforcing divisions between groups.

Another example of how social identity and group membership may contribute to the division between groups can be inferred from another quote from a different participant, this time in response to the question of how he would identify himself when speaking to individuals who are not considered indigenous:

“...I do call myself a comunero because that is what I am...I am from the campo [countryside]...I identify this way...When I go down to the village though, I don’t always get treated well. I have been called indio or cholo. I don’t identify myself as indio, and I don’t like when they call me cholo...This is why I don’t like going to the village. But when I do, I always refer to myself as a comunero, never indio...they are different from us and they disrespect us, you can see this when they call us indio.” (Community Health Worker 1)

A number of social implications can also be inferred from this quote. First, this participant again refers to his regional affiliation and his status as a “community member”, thus reinforcing his membership to the community member in-group. Secondly, this participant relates being treated badly with derogatory name calling by members of the out-group.⁵⁸ This can suggest that being identified with one group (i.e.,

⁵⁸ The identity labels of *indio* and *cholo* are often associated with negative stigma (See Glossary of Terms on p.vii for more information).

indigenous) can influence whether positive or negative behavior is enacted towards other groups. In this case, the participant finds the behavior of the out-group to be negative as evidenced by the poor treatment and name calling and deals with this by presenting himself in terms of his community identity rather than his ethnic identity.

Another form of identity representation referred to by the participants was national identity. National identity markers were also found to be used interchangeably with other identity labels. Several community members spoke proudly about their regional heritage and used these identity labels in response to questions over how they identify themselves. This is indicated in the two quotes below:

“I am Peruvian...I am a campesina (community member)...a hard working Calqueña [from Calca]. I was born in [community 1] and so were my ancestors, and my family...we have been brought up with the same values as our ancestors of this land...this makes me proud to be a Calqueña, and proud to be a Peruvian.” (Community Health Worker 5)

“To me, to be a Peruvian is to be a citizen. My identities, cultural traits and traditions...I feel proud to be a community member, to be Peruvian, to be a Cusqueña [from Cusco Region].” (Community Member 1)

Similar to the previous quotes, various forms of identity markers are evident in the above two quotes. Nationality and citizenship, working status, kinship and ancestry, and culture are all used to reference how the participants identify themselves. Feelings of pride are also expressed in these quotes, such as pride in heritage, and *citizenship* in particular. An interesting point that can be drawn from this is that though participants feel pride in citizenship, they often appear to *lack* social citizenship as exemplified by various forms of social exclusion. As defined in Chapter 2, Section 2.2, social citizenship refers to the varying degrees of access to social rights available to excluded and non-excluded groups. The lack of rights to social citizenship can thus be a leading cause of social and health inequalities and can thereby potentially reinforce the negative stigma associated with being indigenous.

Despite feelings of ancestral pride, other participants described trying to place less emphasis on their indigenous identity when interacting with groups that were not

considered indigenous (i.e., the out-group). The below quote first describes one such case of a participant explaining ancestral pride:

“...Indigeneity is very good. We [community members] consider ourselves to be indigenous communities. Because of the culture. Because of the traditions... We feel happy with this. Because we are descendants of the Incas. That is what interests us. Because here in the communities we are close to their archaeological ruins. Those which they have left us. Because with that, we are part of the Inca. We consider ourselves Inca Wawa, sons of the Inca.”
(Community Health Worker 1)

However, another participant discussed trying to place less emphasis on ancestral pride as indicated below:

“...I am proud to be indigenous, but at the same time, I know this invites discrimination from the people in the towns and cities... Sometimes when I have to go down to the town, I don't always wear my traditional clothes. I would rather blend in sometimes because I get frustrated when the people there treat me badly.” (Community Health Worker 2)

Kreindler et al.'s (2012) five dimensions can be useful to make sense of the above data. As Kreindler et al. (2012) argue, people sometimes distinguish between their in-groups and out-groups. In the above two quotes presented, the two participants both distinguish between their in-group (i.e., indigenous) and those who are not indigenous (i.e., the out-group). The participants also mention cultural traits and traditions which can be illustrated by the third dimension, *Identity Content*. For instance, the second quote provides a good example of how this participant's actions were influenced by identifying as indigenous. Further, by changing clothes and attempting to hide “indigenous” traits, this participant is also choosing to show weaker ties to the indigenous group when interacting with members of non-indigenous groups. This can be illustrated by Dimension 4, *Strength of Identification*, through the action taken to impede identification as an indigenous person. As such, the participant's identity can be interpreted to be fluid depending on the social context, thus relating also to Dimension 5, *Context*.

Another way of categorizing groups as indicated by the data is through group membership based on status and power relations. For example, one participant who worked as a coordinator of social development programs for a municipal government used economic status and forms of livelihoods to differentiate between different Andean groups:

“We are all Andeans, but even so, we all have different experiences and we are different from them [community members]. I studied in the city (Cusco) and now I work in this [government] office. I work here because I had opportunity to study and to make a career. The indigenous aren’t as lucky...They struggle...They work hard in their fields but they don’t have money...or education. They can’t get out of poverty because they are stuck in a cycle. They rely too much on the past...on the traditional ways... There is no opportunity to advance without money or education...to change livelihoods.” (Municipal Worker 3)

The above quote includes two specific identifying markers: *Andean* and *indigenous*. In addition to these identifying markers, this participant discusses how “different experiences” contribute to making indigenous community members “different” from other social identity groups (i.e., the participant’s own identity group). The different experiences referred to are discussed in terms of different career opportunities, with the participant identifying community members as struggling through poverty due to maintaining traditional livelihood practices rather than seeking out a professional career. This example from the data also coincides with Kreindler et al.’s (2012) dimensions of social identity, particularly Dimension 2, *Social Structure*, in that it relates group membership to economic status. This participant’s referral to poverty for instance can be interpreted as reinforcing the division between two groups: those who have financial opportunity and those who do not. In this case indigenous community members are grouped according to their ethnic origin (i.e., indigenous) as well as their status as a group with more limited financial opportunity.

In addition to the identity categorizations already discussed, the most evident form of identity labelling was found to be based on appearance, with particular emphasis on dress style and skin color. The following quote from an NGO worker (who did not

identify as indigenous) provides an example of one popular view of identifying indigenous Andeans:

“...There is sadly a lot of discrimination against the indigenous people here. Skin color...it’s a pretty divisive attribute you know. If they are very brown, then that often leads to very quick judgment from those who are not as brown. Of course clothes are a good giveaway too. I always tell the community members to make sure their clothes are clean and they themselves are bathed and clean if they have to go into town...it just makes it easier you understand.” (NGO Worker 1)

Similarly, a CHW who did identify as indigenous had the following comments when asked to discuss whether identifying as indigenous was viewed positively or negatively:

“Oh, well it depends of course. It depends who you talk to. When I am in my community, I tell the other community members to be proud. To be proud of where we come from and who we are...but it is true though...a lot of times I get called morenita (brown skinned). I know they use it in a nice way, but sometimes I wonder, why is my skin color something to point out? Do I get treated a different way because of this? Yes, I think so.” (Community Health Worker 2)

Again, elements from Kreindler et al.’s (2012) five dimensions are useful for interpreting these quotes. Both participants discussed examples of how the physical attributes of indigenous identity, such as skin color or dress can influence people’s negative or positive attitudes and behaviors towards others. Corresponding to the work of social psychologists such as Tajfel (1981) and Turner et al. (1987), social identity can be “a powerful ingredient in the development of in-group bias and intergroup conflict” (Huddy 2002). Equally, the multiple identity labels used in reference to Cusco’s indigenous community members has been interpreted to be an indicator of the fluidity of social identities. As several scholars have argued, social identities can be multiple depending on the number of groups with which an individual feels affiliated (Akerlof and Kranton 2000; Moss 2008). Likewise, an individual can hold as many personal identities depending on the different idiosyncratic behaviors or group affiliations one possesses (Hogg and Vaughan 2008). The participants in this study are viewed as situated on a broad spectrum of identity classifications which are deeply rooted in the region’s colonial and post-colonial history and multicultural development. Ethnic

identities exist on this spectrum, however, the boundaries between different ethnic classifications indeed seem fluid because they are used interchangeably with other forms of social identity. A Quechua speaking individual native to the Cusco region, for instance, can choose to give up or take on varying external attributes (e.g., avoiding traditional dress) in order to emphasize one ethnic identity over another in an attempt to avoid negative responses. As such, it can be argued that ethnic identity is not necessarily always based on kinship, but also on group membership and social stratification (Nagel 1994). Indigenous and *mestizo* identities, for example, have often been characterized as belonging to a hierarchal system of social stratification as described in Chapter 3, Section 3.2.3. Within the spectrum of identity categorization, indigenous Peruvians have historically fallen below *mestizos* and *mestizos*, correspondingly fall below citizens of Spanish descent (Benavides 2014; de la Cadena 2000; Hudson 1992). In this regard, an indigenous person stressing *mestizo* identity by taking on Spanish cultural traits, such as avoiding traditional dress as described above, theoretically may feel stronger group ties to the *mestizo* group while at the same time feeling a historical bond with the person's original group of origin. This contestation of identities as a means of social mobility forms the crux of the grounded theory resulting from this study and will be detailed in full in the following chapter.

This section has described the various forms of Andean social identities recognized in this study and how the SIA, specifically Kreindler et al.'s (2012) five dimensions of social identity, have been used as a starting point to analyze how participants responded to questions of identity. This approach has offered a useful tool to interpret how different social identities can be used fluidly and interchangeably. It has also provided a meaningful way to categorize the different types of identity labels referred to by the participants. It is important to note, however, that there are also undoubtedly many valid criticisms of the SIA. Some have pointed out weaknesses in the SIA, in that it assumes that social identity is automatic and excludes the possibility of agency, or that it relies too heavily on identifying an ambiguous concept (i.e., identity) (Batalha 2008; Redmond and Graehling 2014). However, by interpreting the data using Kreindler et al.'s (2012)

definition of the SIA which emphasizes the fluidity of social identities, it has been argued that participants exhibited strategic use of the social categories they identified for themselves and others. Most importantly, the data presented above has shown the links between social identities, group membership and divisive behavior, which in turn can lead to exclusion or discrimination based on unequal power relations. Accordingly, the following section describes how these links may result in barriers – or “boundaries” as they are referred to in this study – to the availability, accessibility and quality of maternal health services in the study area.

5.4 The “Social Boundaries of Exclusion”

The indigenous population of the study area faces a significant degree of social and health inequalities when seeking or accessing maternal health services. Such inequalities are interpreted as resulting from a number of barriers, or boundaries to care exacerbated by the SDH. During the past few decades, the concept of “boundaries” has come under renewed interest in disciplines across the social sciences (Lamont and Molnar 2002). Scholars of anthropology, sociology, and political science for instance, have put forth valuable research into understanding the relationship between boundaries and social and collective identities and social inequalities (e.g., class, ethnicity, culture and gender inequalities) (Dean 2011; Elman and Fendius Elman 2001; Hannerz 1997; Lamont and Molnar 2002). Studies into the dynamics of boundaries are not new however. Prominent scholars such as Durkheim, Marx and Weber have analyzed boundaries in terms of religion, capitalist class divisions, and ethnic group status, respectively (Lamont and Molnar 2002). One general theme recognized throughout much of this research, both old and new, concerns the distinction between symbolic boundaries and social boundaries. *Symbolic boundaries* (such as Durkheim’s (2008 [1912]) boundaries between the sacred and profane for example) are abstract in nature and are used by different social actors to categorize different people, objects or practices (Lamont and Molnar 2002). They are, as Epstein writes, conceptual distinctions “...that include and define some people, groups and things while excluding others” (Epstein 1992, p.232). Under this interpretation, they can serve as a means for people of different social groups to generate feelings of group

solidarity and gain status within their own social groups, resulting in exclusion of those out with the groups (Lamont and Molnar 2002). *Social boundaries* on the other hand are “objectified forms of social differences manifested in unequal access to and unequal distribution of resources (material and nonmaterial) and social opportunities” (Lamont and Molnar 2002, p.168). Accordingly, social boundaries also include *institutional boundaries*, as exclusion occurs when the state is unable or unwilling to successfully respond to the needs and rights of all of its citizens. Lamont and Molnar (2002, p.168-169) further state that “only when symbolic boundaries are widely agreed upon can they take on a constraining character... and become social boundaries and pattern social interaction in important ways”. Boundaries are thus understood to be a catalyst for inequality and uneven power relations (Lamont 2001).

The relationship between symbolic and social boundaries is significant for this study because they were both interpreted to play an important role in constructing, maintaining or even contesting institutionalized social differences (e.g., ethnic, cultural, gender based) between the different groups of this study, and accordingly, the different actors of the health system. The prevalence of institutionalized social inequalities in the Andes, which result from a variety of socio-historical factors as discussed throughout this thesis, pose a major barrier to indigenous Andeans in need of maternal health services. The high rates of maternal mortality in the rural Andes are a result of a number of boundaries the indigenous population faces when seeking or utilizing maternal health services. Influenced by symbolic boundaries (such as Quechua cultural traditions or different ways of conceptualizing the social world), a number of social boundaries were found to impede the accessibility, acceptability and quality of maternal health services. The social boundaries found most prominently in this study have thus been labeled: *The Social Boundaries of Exclusion*. Specifically, these include boundaries based on ethnicity, cultural practices, gender, education, language and institutional exclusion. The following subsections discuss each of these boundaries in turn using examples from the data to interpret how they were found to influence the utilization and delivery of maternal health services in Cusco’s rural communities.

5.4.1 Ethnic Boundaries

The first social boundary to be discussed occurs as a result of ethnic exclusion. As discussed in Chapter 3, social discrimination is pervasive throughout Peru. Interestingly as many studies have pointed out, much of this discrimination is justified as a result of cultural differences rather than innate biological differences (Canepa 2008; de la Cadena 2000; Figueroa and Barrón 2005; Garcia 2005; Paredes 2007). A common argument in favor of this position, as described in Chapter 3, Sections 3.3 and 3.4, is based on the dichotomous view that associates the indigenous population with a primitive and rural lifestyle, and thus an inferior social status, while the non-indigenous are more often associated with urbanity, literacy and financial success, granting a higher social status (D'Andrea 2007). This study however interprets social discrimination to occur as a result of both ethnic differences as well as cultural differences. If the concept of ethnicity is to be understood as a group of individuals with a shared ancestral connection, then it can be argued that cultural practices developed and shared by the same ethnic group over time, also make up a closely intertwined element of ethnicity (D'Andrea 2007). As such, ethnic exclusion characterized by both ethnic and cultural traits were interpreted as posing a significant social boundary for both health seekers as well as providers and coordinators of maternal health services in the rural Andean communities of this study. The traits which were most frequently referred to as leading to discrimination and exclusion from health services were discussed in terms of visible attributes such as skin color, hygiene and clothing as the following three quotes indicate:

“The women in the communities don’t like to go to the health facilities. It is true they [health professionals] treat them bad there. We are different than them you see. My skin is dark and I wear traditional clothes. But even when I dress like them...my skin is still darker than theirs. They think we are backwards. We have our own customs but it doesn’t matter if we hide these from them. We are still Indians to them.” (Community Health Worker 4)

“I know it’s better if my children and I look clean when we go to see the doctor. Sometimes I can’t help it though. It is a long walk and even if I scrub my sandals and feet before I start [walking], they will get dirty again once I’m down there. And my children run around so much! They love to play and I can’t keep the dirt off of them. I know this is why they [health post staff] look at me like I’m not

worth anything. They give me dirty looks and don't treat me well." (Community Member 1)

"When we train our CHWs, we make sure they are always well dressed and groomed. They take a lot of pride in this...their feet are always as clean as can be...given the amount of walking in the dirt they have to do⁵⁹...they should always have clean clothes too. If they look dirty or too poor, the nurses will take one look at them and treat them like Indians." (NGO Worker 1)

A consistent theme evident in each of the above quotes is the common association of outward appearance with indigenous discrimination. Of particular interest is the assertion made by Community Health Worker 4 in the first quote above stating: "even when I dress like them...my skin is still darker than theirs". Statements such as this problematize the dichotomous view that an individual is either indigenous or non-indigenous and highlights the ambiguousness of *mestizaje*. As introduced in Chapter 3 Section 3.3, the concept of *mestizaje* has historically assumed the existence of a cultural transition between indigenous and non-indigenous that is paralleled with the transition between rural to urban, illiterate to literate, unclean to clean, among others (D'Andrea 2007). However, as stated above, despite changing one's clothes or appearance to try to assimilate into a non-indigenous lifestyle, the genetic features of skin color tying an individual to their biological ancestry continue to be perceived as indigenous, and thus make one more susceptible to discrimination. Therefore, even if an individual has achieved higher education or financial success, thereby more closely aligning him or herself to the *mestizo* or non-indigenous identity categorizations for instance, that individual would still also belong to the indigenous group given his or her ancestral background (de la Cadena 2000). This is consistent with research conducted by scholars such as Canepa (2008) and Garcia (2005) who both examine the fluidity (and limitations to fluidity) of identity categories in Peru and the role of appearance in generating discrimination.

In addition to the relationship between physical appearance and ethnic exclusion, another common theme inferred from the findings was that of the context dependent

⁵⁹ Indigenous Andeans generally wear *ojotas* (open toed sandals).

classifications of ethnic identity. This was namely evident in the ways participants chose to identify themselves during encounters with members of different groups (i.e., out-groups) in contrast to members of the same group (i.e., in-group). The following quotes, for instance, demonstrate how some participants from the community member and CHW groups chose to place less emphasis on indigenous identity when interacting with health professionals (i.e., their out-group).

“My ethnic identity, that of Quechua [indigenous Andean], is something I am proud of. At the same time though, I know that this sets me back. We do get discrimination, we do get treated badly by them [non-indigenous]. This is why many of the women in my community don’t want to go to the health posts...but when they do, I tell them to at least take care to not bring too much attention to themselves. To take care to look clean, to look like them.” (Community Health Worker 5)

“I am indigenous to this land. We [indigenous campesinos] inherited this land from our great ancestors, the Inca. This is a great source of pride for us you know. But we also suffer for this... We have been marginalized and this shows in the way the doctors treat us and our women... This is why I tell my wife to not speak too much when we go to the health post, to not give away that she does not know as much Spanish.” (Community Member 4)

The first quote above, particularly reflects how the expectation of poor or disrespectful treatment resulting from ethnic discrimination can cause indigenous women to be reluctant to go to the health posts. Further, both of these quotes also correspond to Kreindler et al.’s (2012) fourth dimension of the SIA, *Strength of Identification*, as these participants place less emphasis on displaying the physical attributes of their ethnic identity. Thus, similar to the arguments presented in Section 5.3, participants seem to be managing the various features of social identity in order to reduce their risk of exclusion. Likewise, the following quotes present additional examples of pragmatically managing social identity, but this time with indigenous Andeans placing more emphasis on their indigenous identity while interacting with members of the same group (i.e., in-group):

“...when we find ourselves with people from the communities, with people from this community here [Community 3], well then, we are proud to know ourselves as indigenous. But when we find ourselves with people in the town, like in the health center, well then that is when they marginalize us. Why? First of all it is

because of our clothes. 'These clothes are too cheap, these clothes are worthless' is what they say." (Community Health Worker 1)

"You ask me how I identify myself...I am from [Community 8]. This is how people know me...this is who I am...the problem is that when we tell the women to go down to the health post for their checkups, it's not always a good experience for them...but when they talk to me, then they are comfortable, we are all campesinos...we are indigenous. This is who we are and we understand each other because of this." (Community Health Worker 3)

In contrast to the examples given of community health workers placing less emphasis on their indigenous identity while interacting with members of an out-group, the above quotes indicate that community members feel more comfortable emphasizing indigenous identity when interacting with other community members. This could be indicative of the way boundaries can create group solidarity among members of the same group while also reinforcing discrimination based on ethnic attributes. Consequently, ethnic identity has been identified as a significant social boundary contributing to exclusion from the health services.

5.4.2 Cultural Boundaries

The second of the social boundaries of exclusion to be discussed are cultural boundaries. Cultural boundaries as used in this study refer to the barriers hindering the access or delivery of maternal health services caused by different cultural understandings and approaches to illness and health care (See Chapter 2, Section 2.4.2). In Cusco, a form of medical pluralism is evident in the way health services are carried out.⁶⁰ In the study area, the traditional beliefs and approaches to health and medicine practiced by indigenous Andeans coexist with the formal health system's preferred biomedical model of care. These two models of health care do exist in juxtaposition with each other; however findings from this study suggest that the biomedical model does not always meet the needs, preferences or expectations of indigenous Andean women. Participants from each of the five participant groups, for instance, consistently and frequently cited

⁶⁰ Medical pluralism refers to the adoption of more than one health system. Key scholars who have examined medical pluralism include medical anthropologists Kleinman (1978) and Lambert (1998).

cultural differences in health care preferences as the leading indirect cause of maternal mortality, morbidity or near misses. Several participants commented that complications experienced during pregnancy, childbirth and the postpartum period were mainly due to indigenous women's reluctance or refusal to utilize formal health services or seek maternal care from skilled health professionals. Some reasons for the limited use of formal health services as identified by indigenous Andean women included preferring traditional medicine over western medical models and feeling scared or uncomfortable in the presence of strangers, such as the doctors and nurses at the health facilities. These findings are consistent with findings from previous studies which have similarly identified cultural differences resulting in avoidance of formal maternal health services as one of the main factors contributing to maternal mortality in Peru (Amnesty International 2009a; Amnesty International 2009b; Bristol 2009; Physicians for Human Rights 2007). The following interview excerpts taken from three different interviews with two community women and a community health worker, respectively, provide examples of some of the reasons indigenous Andeans avoid formal health services:

"The doctors don't know about our illnesses and sometimes if they make us take their medicines that they give us, we might suffer more. The health promoter knows what medicines we need...we are just fine here [in the community]."
(Community Member 3)

"I wouldn't want to go to the health post to give birth. The doctors don't need to watch me give birth...the medicines at the health post aren't for us. We have everything we need here [in the community] and if anything happens, the promoter [community health worker], or our neighbors are nearby to help."
(Community Member 1)

"It is not good when the women go down to give birth at the health post. This is risky for them because they [health post staff] don't know the medicines that are good for them [the women] or how to treat them the way they should be treated. We take care of them here. A woman has a better chance of having a good birth here with her family then down there [at the health post]." (Community Health Worker 6)

Two key issues can be inferred from these quotes. First, there seems to be a sense of "othering" on the basis of differing cultural beliefs over health and illness, characteristic of the us versus them dichotomy, occurring between indigenous Andeans and the health

professionals. Second, it is interesting that the above CHW does not recommend giving birth in the health center. Despite the significant efforts made by health professionals and policy makers to emphasize facility based childbirth, this CHW views the health facilities as posing a greater risk for pregnant women than home births. This points to a significant disconnect between the way the health system is organized and the actual needs of potential health users. The reasons for this can be linked to complications arising from a pluralistic health setting. In the communities of this study for example, it was observed that biomedical health approaches are usually seen as just one option for treatment that is often chosen as a last resort. The health system and all of its actors (i.e., health professionals, policy makers) however, consider the biomedical approach to be the only safe method of care, thus devaluing Andean beliefs. Health professionals, for example, also commented on indigenous Andean's reluctance to use formal health services and reported feeling frustrated at community members' overreliance on traditional remedies and avoidance of the medicines they prescribe to them as indicated by the following two quotes:

"...we tell them which medicines to take, but they still rely on their healers instead of us. Sometimes a woman needs a certain medicine but she won't take it. She'll tell me that the medicine will harm her, that it doesn't get rid of the spirit possessing her body...This [refusal of medicine] can be bad for her and for the baby...I get frustrated because a lot of times they don't take my advice..."
(Obstetrician 1)

"...when I told her [community woman] that she needed to take her iron supplements, she said she would...but then when I saw her again, I found out that she hadn't taken any...it's because they don't understand that supplements are important! If it's not an antibiotic, they won't take it! I explain to them all the time the difference between bacterial and viral infections...but they just don't understand and this is dangerous." (Obstetrician 3)

Again, an important implication that can be inferred from the presented data is the potential for tensions arising as a result of conflicting models of health care. The above quotes, for instance, provide further examples of each group's differing cultural perceptions regarding "western medicines". Each of the three participants from the community member and CHW groups that were quoted previously identify "western",

or biomedical forms of medicine, as harmful and not suited for indigenous Andeans. This was not a surprising finding considering the significant differences between the Andean belief system regarding health and illness and biomedical approaches to health as discussed in Chapter 3, Section 3.5.1. However, the two health professionals quoted above described attempts to treat indigenous Andean women with medicines or iron supplements, but these attempts were rejected by the women. The indigenous Andean women's rejections of the medicines can likely be attributed to traditional Andean belief systems which view western medicines as potentially harmful. From this, it can be inferred that indigenous Andeans may feel that biomedical care, such as western medicine, is a foreign concept which does not meet their needs. In contrast, health professionals generally hold the view that biomedical models are necessary to prevent and treat complications which may arise during pregnancy. The evidence thus suggests that these different approaches to health care may manifest as cultural barriers hindering the utilization and delivery of formal maternal health services. Further, there seems to be little dialogue between the different actors over how these differences should be dealt with, thus reinforcing cultural barriers.

These findings are in accordance with previous studies which have also examined the barriers to health care resulting from attempts to impose biomedical health practices in Peru's indigenous communities (Garcia 2009; Garrafa and Garrafa 2009). Bristol (2009), for instance, describes how culturally inappropriate maternal health services deter many indigenous women from seeking formal health care. The findings from this study thus corroborate previous research and suggest that cultural preferences over the ways health services are delivered pose a significant barrier to indigenous Andean women who may be in need of skilled or integrated care throughout their pregnancies.

In addition to differing beliefs over pharmaceuticals, pregnant and postpartum women in the communities reported feeling scared and embarrassed during examinations by formal health professionals, in particular if the health professional was male. Some more examples of how different cultural practices, such different expectations over the

external environment of the birthing room, might act as a barrier for indigenous Andeans accessing formal health services are presented in the following quotes:

“The room [at the health center] was very bright and cold and they wanted me to undress completely. I just had a sheet and a robe...There were a lot of people in the room and I felt embarrassed for them to see me.” (Community Member 2)

“The doctors and nurses at the health post make me undress and they take off my cover all the time. Their hands are always cold and they constantly touch me and grab my stomach. There are always so many strange people around me. They don’t need to do this...going to the health post makes me scared”. (Community Member 3)

These quotes suggest that the fear, discomfort or embarrassment experienced by indigenous women in the health center can be due to conflicting cultural beliefs regarding health care and childbirth preferences. As spiritual and religious beliefs play a large part in informing indigenous Andean health practices, many indigenous Andean women find the cold sterile environment of the health centers strange and potentially harmful. As described in Chapter 3, Section 3.5.1, Andean women, prefer to remain clothed or covered during examinations and childbirth and believe that coming into contact with the cold poses risk to them and their babies (Garcia 2009). The participants living in the study area, for instance, considered pregnancy and lactation to be “hot” elements, therefore according to indigenous Andean beliefs, pregnant and postpartum women’s bodies must always be protected against the cold in order to prevent potential illnesses which may harm them or the developing fetus.⁶¹

In addition to the potential for harm resulting from exposure to the cold, the above quotes also indicate different cultural preferences regarding modesty during examinations and childbirth. Previous studies have found that indigenous Andean women place a high value on modesty (Amnesty International 2009a; Amnesty International 2009b; Bristol 2009; Physicians for Human Rights 2007). A medical environment that is cold, brightly lit and overcrowded with strangers can cause anxiety

⁶¹ Hot and cold beliefs are also prevalent in many traditional belief systems found in Asia and East Africa (Carteret 2011).

for indigenous Andean women who prefer to follow a specific set of childbirth rituals involving giving birth in a dark, warm room while in the company of family. It can thus be inferred that these differences in the style of care may result in indigenous Andean women feeling fear and discomfort while visiting health facilities.

The examples provided highlight the importance of developing and delivering health services which can be adapted to the beliefs and attitudes of the people such services are intended for.⁶² Cultural boundaries as they have been described in this section thus constitute a significant barrier to the utilization and delivery of maternal health services. The above examples indicate that a key problem results from tensions arising from the coexistence of the two models of health care. The disease-centered care model associated with biomedical health systems conflicts with the Andean community-centered approach to health and illness. The biomedical model, which traces back to Cartesian notions of mind-body dualism⁶³ has largely been guided by defining disease in terms of biophysical malfunction (Annandale 1998). Such a model reduces illness or disease into a treatable or untreatable condition which excludes external factors such as personal experiences of illness. The biomedical model's emphasis on the individual thus stands in stark contrast to traditional Andean health beliefs which emphasize personal experience, external elements and community involvement as the main causes of ill health. This is made evident by scholars such as Quevedo Pereyra de Prebyl (2013) as well as findings from this study which underscores the necessity of meeting the cultural needs and expectations of the services' intended recipients.

5.4.3 Gender Boundaries

⁶² Despite the implementation of health policies aimed to provide culturally adapted childbirth services to all indigenous women in 2005, many indigenous women are still reluctant to use services. Potential causes for this will be discussed throughout the remainder of this chapter.

⁶³ The mind-body problem was most notably examined in the 17th century by René Descartes. The resulting Cartesian dualism considers mental and physical phenomena as distinct from each other (Calef n.d.).

Gender boundaries have been identified as another prevalent cause of exclusion from maternal health services in the Andes. As discussed in Chapter 3, Section 3.4.1, Peru as a whole maintains a strongly patriarchal society. Gender inequalities and the resulting lack of agency women have over their own bodies were issues which were brought up frequently by various participants in this study. For example, some of the main themes discussed among participants in regard to gender inequalities and maternal health concerned the lack of women's decision making authority for family planning.⁶⁴ This is demonstrated in the following quotes:

"...they [community women] have too many children...they need to practice family planning...more than just the withdrawal method. I told the women about different forms of birth control during the last community talk...I told them what we [CHWs] learned during the last training workshop. They just laughed like they were embarrassed. It doesn't matter if I tell the women though, it's the husbands that need to be talked to. But they think we are trying to take away their rights as men if we try to help them have less children." (Community Health Worker 6)

"Rural women in Peru, especially here in these communities [of Cusco] don't have a lot of say in what happens to their bodies. They have too many children...and too frequently. Birth spacing is a real problem in their culture...And a lot of times this is because the men don't follow any kind of family planning, or let their wives visit the health center...we [NGO workers] really struggle to help the women learn that they have rights, that their husbands don't always have to tell them what to do." (NGO Worker 3)

The above quotes provide just some examples of how a lack of women's agency and decision making power can influence family planning methods or whether or not care is sought if needed. As the men traditionally govern family planning decisions, women in Andean communities are often unable to control the frequency of their pregnancies. This leaves women vulnerable to short birth spacing, therefore potentially leading to high risk pregnancies or complications during, or after childbirth (Davanzo et al. 2004). The following quotes also attribute gender based exclusion from health services to patriarchal decision-making power imbalances:

⁶⁴ Family planning is included as an essential component of maternal health services because it falls on the continuum of care as discussed in Section 2.4.

“A lot of times the husbands are the ones that don’t let their women go down to the health post. They say if their cows and llamas give birth in the fields, why shouldn’t their women? This is what stops many women from coming down here...” (Medical Doctor 2)

“I tell them [the community women] many times that they have to make sure they are taking care to plan their families...They have so many children and they wonder why they are always poor. It’s because of their customs...The men feel that we are taking away their rights if we even talk about contraception...The men need to be sensitized just as much as the women. That way they might take more care and the services would help them more...if the men are involved.” (Municipal Worker 2)

Similar to the first two quotes describing gender boundaries, the above quote given by the municipal worker identifies the involvement of men as essential to encouraging family planning and greater use of maternal health services. Accordingly, for the above two participants, the patriarchal customs characteristic to Andean communities are seen as a contributing factor in the lack of contraception which results in too many pregnancies. Again, raising men’s awareness of family planning needs is referred to as a possible solution, thus implying that men hold greater responsibility and authority over such decisions.

Further to women’s lack of autonomy and finances in family planning or seeking care, social problems such as possible disinterest in family responsibilities and alcoholism among men were also frequently mentioned in relation to gender inequalities. The following quotes provide examples of how these social problems might influence Andean women’s maternal health care choices:

“At the end of my last pregnancy, I went to go live in the mamawasi [maternal waiting home]. I was there for more than six days...my husband and my small children were left at home...they didn’t have anybody to cook for them or take care of them. I was worried leaving my husband alone...I was worried he wouldn’t look after the children or he would spend all of his money.” (Community Member 2)

“Many of the campesinos are lazy and alcoholism is a big problem. The men spend all their money on alcohol and this affects the lives of their women and children.” (Municipal Worker 1)

The above municipal worker also referred to an implied lack of interest from the community men:

“I tell them to make sure their women are eating well getting the right care for their babies but it just seems like they don’t listen. I try to make sure they are attending our talks, to make sure they are listening when I tell them to send their women down to the health post if they need to go...but when I tell them, sometimes they just laugh, and that’s it....” (Municipal Worker 1)

For the above municipal worker, the emphasis is placed on alcohol misuse and the financial and patriarchal control community men have over their families. Despite providing the community men with information and advising them of their expected role in ensuring community women’s maternal health needs are being met, many men are seen to respond with inattentiveness or indifference (e.g., as expressed through the response of laughter). This quote indicates that this participant holds the view that the actions (or inactions) of the community men have a direct effect on the health of their female family members. This municipal worker attributes the men’s attitudes of inattentiveness or indifference to be faulted for the underutilization of services. In this sense, the municipal worker, despite having the professional responsibility of coordinating community development activities equally identifies the community men as holding a greater degree of responsibility and authority over their own families’ health needs.

The gender boundaries discussed in this section highlight some of the more complicated social issues which can contribute to exclusion in the region. One such implication is the tendency to attribute differing cultural beliefs such as patriarchal authority as one of the leading causes of exclusion. The inclination to conflate culturally specific attitudes towards gender with exclusion in general has been discussed by a number of scholars. Cameron & Lalonde (2001, p.59) for example, examine how gender stereotypes relate to inequalities, stating that “gender is associated with deeply entrenched power and status differentials; that is, in terms of a variety of social, political and economic outcomes, men can be regarded as the more advantaged group”. This seems consistent with the findings from this study. For example, in the second quote made by NGO Worker 3

(p.187), the participant refers to “culture” as a factor affecting birth spacing. This may be indicative of attributing some high risk behaviors (e.g., short birth spacing) to different cultural practices or beliefs, in this case, male authority over family planning decisions. However, the NGO worker’s assertion of culture as a factor can be contested given that gender inequalities and patriarchal attitudes are present throughout the rest of Peruvian society as well. As such, assumptions that patriarchal attitudes among the indigenous population are purely a result of cultural differences between indigenous and non-indigenous groups can equally be contested. Jeffery et al. (2007, p.286) for instance, explain how the tendency to blame high maternal mortality rates on cultural characteristics can lead to victim-blaming which consequently “...distracts attention from the need for better quality health and delivery services”. Automatically placing blame on culture rather than focusing on other potential causes of exclusion thus highlights another likely disconnect between what is being emphasized in strategies to improve maternal health services and what should instead be emphasized given the actual needs of potential service users.

5.4.4 Education Boundaries

Along with ethnic, cultural and gender boundaries, several participants referred to education as another leading form of exclusion. Because of extreme poverty in many of the communities, access to long term education for community members is limited, thus also contributing to a lack of access to information regarding sexual and reproductive health or maternal health. The following quote, for instance, describes the experience of one CHW:

“...I went to school for just a few years...and I started late. The journey to my school was too much so I stayed home until I was old enough to be able to make it all the way. Sometimes I feel like I am not as informed as the people that come from the cities and I feel that they look down on me for this. Before I became a health promoter I didn’t understand much about reproduction. We didn’t talk about that at home and I only learned about it when I started attending the CHW workshops.” (Community Health Worker 3)

This participant raises two main examples of how limited access to education can contribute to exclusion from health services and poor maternal health outcomes. First, it is common in rural communities for children to enter late into the school system because of a lack of transportation or also due to having to work to assist with familial economic responsibilities (D'Andrea 2007; Garcia 2005). Moreover, the quality of education in rural areas is often significantly lower than in urban areas (D'Andrea 2007; Garcia 2005). As a result, many indigenous people have reported experiencing discrimination when in urban areas due to their comparatively lower education. The second point raised by the above participant is the limited knowledge regarding reproduction. Modesty is a common characteristic of indigenous Andean culture and issues such as reproduction, family planning, or maternal health are generally not discussed in households (Physicians for Human Rights 2007). A lack of knowledge concerning sexual and reproductive health has historically been associated with a number of risk factors such as frequent pregnancies and short birth spacing, insufficient nutrition during pregnancy, limited utilization of prenatal care and complications during childbirth, among others (Physicians for Human Rights 2007).

Another example of how limited access to education can act as a social boundary of exclusion is the high prevalence of illiteracy among indigenous community members. With one of the highest illiteracy rates in Latin America,⁶⁵ Peru's indigenous population has historically been excluded from advancing into higher education and thus raising their career prospects (D'Andrea 2007). In addition to excluding the rural population from social mobility however, illiteracy also poses a problem when seeking or receiving maternal health services, such as being unable to read prescription information as the following quote indicates:

"...I don't read. This is a problem...I don't write either. So when the doctor gives me instructions about how to take my medicine or any other type of information, I have to remember it. If I don't remember, well I don't remember,

⁶⁵ In 2007, the total adult (age 15 and above) literacy rate in Peru was 89.59%, however the majority of those who are illiterate are mostly women in rural areas (Index Mundi 2007).

what can I do? I'm too far away from the health post to go back and ask. I just have to wait for the doctor or nurse to visit us here if they do. And then, just hope that nothing has happened to me before that.” (Community Member 2)

The first line of this quote specifies illiteracy as a problem. For this participant, not being able to read or write poses a barrier to following medical advice. This is particularly the case in terms of having to remember doctors' instructions following maternal health visits. Thus, without being able to write down instructions or have the doctor provide written information, this participant has to rely on memory. Further, given the lack of telecommunications in most of the rural communities along with the distances between the communities and the health posts, this participant doesn't have the option to travel as frequently as needed to the health posts. The final line of this quote where the participant expresses having to hope that “nothing has happened to [her] before that” can be interpreted to indicate the potential loss of agency over this participant's own health due to having to rely on the doctor visiting the community rather than having written information she can refer to as needed.

Much like cultural boundaries, gender boundaries are also present in education based exclusion. For example, as indigenous Andeans follow a largely patriarchal worldview, women are less likely than men to be granted full access to the education system (D'Andrea 2007; Garcia 2005). Women are thus frequently excluded from education and consequently access to information or knowledge that will allow them to maintain healthy practices. The following quote provides an example of this:

“I stay down here in the town because I am working as a cleaner in the health post. I would like to go back to [Community 10], but I think it is better here...better for my children. The school is better here. I didn't go to school after I was 14, I had to work in the fields to help make money. But I want my children to go to school for longer, so that they can learn important things...But I don't think I will be able to afford to keep them all in school. The boys at least will go because that will give them more opportunity in life.” (Community Member 1)

This quote is consistent with the perception (and possible reality) that schools are generally thought to be better in urban areas. Additionally, this participant expresses her wishes for her children to be educated in order to have more opportunities. However

given financial constraints, this participant would send the male children to school over the female children. Situations such as this are not uncommon in rural Andean communities and have been described in more detail in studies by Garcia (2005) and D'Andrea (2007). In response to being asked to elaborate on why this participant would choose to educate one gender over another, the participant stated:

“Well, if I only have enough [money] to send one to school, it makes sense to send my son. He is the one that will be in charge of the money. My daughters will eventually get married and then their husbands will be in charge of the money. This is how it works...If I had to make a choice, my son would go to school first.”
(Community Woman 1)

As can be noted by this quote, the gender divisions explained in the previous subsection can give rise to reinforcing boundaries to education, in particular among women. Women's unequal access to education can pose a further problem in terms of limiting their knowledge of essential reproductive and maternal health issues as has been described. Consequently, this has likely contributed to the underutilization of essential maternal health services among the rural population.

The relationship between knowledge gaps resulting from limited education among both men and women and the underutilization of maternal health services were also discussed frequently by members of the other participant groups. Several health professionals for instance described the community members' limited knowledge of the reproductive process and family planning methods as another leading factor contributing to complications arising during or after pregnancy. The next quote demonstrates the point of view of a general practice medical doctor when asked to describe his opinion as to why women don't always visit the health facilities or adhere to medical advice:

“What is missing is education...it is not just the geographic accessibility, but their culture, education and upbringing that lead them to have a particular fear to give birth in a health facility...Their customs are very family oriented and keep them in the communities. They know they are supposed to attend their checkups but they don't always. This is very risky for them and for their babies.”
(Medical Doctor 3)

For this participant, education and cultural customs are seen to be closely intertwined. His description indicates that he feels greater education would serve to relieve the fear that indigenous Andean women feel when giving birth in a health facility. In this sense, the above participant is operating under the assumption that the cultural practices of indigenous Andean women in regards to maternal health care may be inferior to biomedical practices, thus potentially leading to riskier health outcomes.

5.4.5 Language Boundaries

Language boundaries were also found to play a significant role in contributing to indigenous exclusion among rural Andean communities. Although Spanish and Quechua are both recognized as official languages in Peru, Spanish is the language in which the government, education system and health system operates (Physicians for Human Rights 2007). This has several implications for the way health services are experienced in Andean communities. As the majority of Peru's Andean population primarily speak Quechua, miscommunication or misunderstanding between community members and health service providers and coordinators were found to occur frequently. Further, ethnic, culture, gender and education boundaries also closely correspond to exclusion based on language limitations (Kabeer 2006; Physicians for Human Rights 2006). For example, as women are more often excluded from a full education as discussed above, they are more likely to have less knowledge of Spanish than men. Knowledge gaps over reproductive health matters among women are often compounded by having a limited understanding of Spanish. As such, language barriers pose a significant boundary to the accessibility and quality of maternal health services received. Despite some of the health professionals and government and NGO workers having varying degrees of knowledge of Quechua as described in Section 5.2.2, many of the medical terms they use while discussing health needs are in Spanish and thus not always understood among native Quechua speakers. For pregnant and postpartum women in the communities, this can result in not understanding what the health professionals advise them to do to maintain good health and hygiene during and after pregnancy and labor in order to prevent complications. The potential for limited understanding can thus give rise to

underutilization or avoidance of formal health services. This is reflected in the following quotes from interviews with two separate community women:

“I don’t understand the doctors when they talk to me. The young lady doctor speaks in Spanish, and only sometimes uses Quechua words. She explained to me something about vitamins to help the baby grow but I didn’t understand. She wrote it on a piece of paper for me to take with me but I didn’t understand that either because I don’t read.” (Community Member 2)

“The last time I went to the health post, the nurses talked to me in Spanish. I didn’t really understand a lot of what they were trying to tell me. One of the nurses kept repeating her instructions about the medicine I should take but I don’t remember everything she said. I didn’t understand. Then when she came up to the community to see me later, she yelled at me for not following her instructions. I didn’t really understand a lot of what she was saying though.” (Community Member 3)

The above quotes thus provide some examples of community women’s experiences with language limitations. Insufficient knowledge of Spanish can pose barriers to the access of maternal health services as well as negatively influencing the quality of health services which are delivered. Further, in the second quote above, the community woman describes being yelled at by the nurse because she did not follow the nurse’s medical instructions. The reaction of the nurse could possibly be interpreted as resulting from frustration at not being listened to; however the community woman above describes not understanding what the nurse was telling her. Equally, the nurse’s reaction could be reflective of the tendency to place blame on the community members rather than focusing on weaknesses in the health system (Jeffery et al. 2007). The following quotes obtained from an interview with an obstetrician and medical doctor respectively considers these issues from the perspective of health providers:

“Like I said, it seems the women just don’t listen to us. When we [obstetricians] first started going into the communities, we were always really nice to them and offered them as much information and services as we could...the women started taking advantage of our kindness and didn’t treat us well or didn’t pay attention to the advice we were giving them.” (Obstetrician 1)

“They don’t have enough Spanish. We do speak to them in Quechua when we can but mostly either the medical staff don’t have enough Quechua knowledge or

the campesinos don't have as much, or any Spanish ability...it's a problem here." (Medical doctor 2)

The quotes presented in this section again predominantly reflect the seeming disconnect, or misunderstanding of information occurring between community members and health professionals. While most of the community members reported feeling mistreated or disrespected by the health staff, many of the health professionals felt that they were doing the best they could to provide a high quality of care to their patients. All of the health professionals interviewed acknowledged being aware of this possible disconnect, however, any instances of misunderstanding were mainly attributed to language and cultural differences. Similar to the cultural boundaries discussed in Section 5.4.2, such miscommunication between health seekers and providers resulting from language barriers can also be interpreted as an example of institutional exclusion, or institutional boundaries to care as will be explained in the following subsections.

5.4.6 Institutional Boundaries to Andean Maternal Health Services

Each of the boundaries discussed thus far have all been shown to impede the accessibility, acceptability and quality of maternal health services. Not surprisingly, discriminatory practices resulting from the social boundaries of exclusion are also deeply embedded in formal institutions of the state such the health system. According to the World Health Organization (2015b, para.1):

A good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality medicines and technologies.

A health system, therefore, is ideally developed to equally meet the needs of all of the citizens they are meant to serve. As such, it would be appropriate to assume that the policies of the Peruvian health system would try to incorporate equitable health care in its practices. However, a number of institutional boundaries were also found to contribute to underutilization of maternal health services. Consequently, some of the

leading boundaries to care leading to maternal complications were found within the structure of the health system itself. For example, an analysis of the structure of the health system along with the experiences of the various actors utilizing or working within the system led to the identification of three major factors preventing women from seeking or receiving acceptable maternal health services. First, challenges were found in implementing culturally adapted maternity services; second, recruitment and retention among health professionals working in rural areas posed a problem for the quality of care available to rural Andean women; and third, there were some instances where the health system seemed to place more value on saving the life of the newborn over that of the mother, thus potentially contributing to poorer quality of care for pregnant and postpartum women. Each of these factors will be discussed in the following subsections with examples from the data.

5.4.6.1 Culturally Adapted Maternity in Practice

The Peruvian government has made several efforts over the past few decades to contribute to international and national initiatives to reduce maternal mortality and reach the fifth MDG goal.⁶⁶ As discussed in chapter 3, Sections 3.5.1 and 3.6.3, in 2005, the Peruvian government adopted an intercultural health policy designed to encourage facility based childbirth and the use of skilled birth attendance. This was done through implementing culturally adapted maternity services, such as offering vertical births and the establishment of maternal waiting homes near district health centers for the indigenous Andean population. As described in Section 5.4.2 however, these services are not always available, and if they are, the data indicates that they are underutilized or neglected all together. Some of the reasons given for this are a lack of knowledge (by both health seekers and providers) of the availability of such services, inaccessibility due to child and home caring responsibilities, and also inaccessibility due to vast geographic

⁶⁶ See Chapter 2 for a discussion of the background of national and international strategies to meet maternal health goals.

distances. The following quotes provide some examples of why culturally adapted services may be underutilized:

“The health center is equipped for vertical birthing, but the women seldom ask for it. Usually this is because they [the women] don’t even know it is a possibility for them. For as long as I have lived in [Town 2], I have never heard of doctors offering the women these services...it’s inconvenient for them [doctors], you see. It’s a different approach and they prefer the method they were trained in.” (NGO Worker 1)

“I do know about the mamawasi. But I wouldn’t stay in it. When I told the nurse I wasn’t going back there with this baby, she yelled at me and she was very disrespectful to me. She said that the mamawasi is here to make sure I’m safe when I give birth. But the nurses don’t understand our situation. I know they have these facilities but I can’t just leave my family for weeks at a time when I can comfortably have my baby at home.” (Community Member 1)

The above two quotes refer to intercultural health services and maternal waiting homes respectively, the two main interventions implemented with the goal to reduce maternal mortality in Andean communities. Both of these interventions were developed by the Ministry of Health in an attempt to decrease complications arising from home births. However, close analysis of the experiences referred to in the above quotes further demonstrate that the actual needs of the target population (i.e., the indigenous population) are not always being fully met. Therefore, although there may be an intercultural health policy, it is not always deemed important by providers and thus not always implemented. Further, both quotes show evidence of discrimination and verbal abuse from health professionals. Similar to previous examples, maltreatment by health professionals is often explained as a result of expressing frustration over cultural differences when community members do not follow medical advice as indicated in the following quotes:

“...I don’t yell at them, but I do raise my voice when I talk to them...you have to speak to them like this, to be stern with them. It’s the only way they will understand. Otherwise they don’t listen. They don’t pay attention. This does frustrate me because I am working to help them, but it is in their culture to not listen to us.” (Medical Doctor 2)

“It’s like time has stood still for them. Once you go up into the mountains, everything is just as it was five hundred years ago. The world around them is changing but they wouldn’t know it...They will always be Indians. They remain doing things in their traditional ways when it is not always good for them...they give birth at home with their teas and soups but if there is a complication...Living in the past like this...when there are so many medical advances to help monitor the baby...but they still refuse care... they will always stay behind like this unless they change some of their habits.” (Medical Doctor 1)

There are several points which can be inferred from these quotes. In the first quote above, Medical Doctor 2 refers to having to speak to indigenous community members in a raised voice in order for them to pay attention or to listen to medical advice. This is problematic however because indigenous community members, such as Community Member 1 who was yelled at by the nurse for not wanting to stay in the *mamawasi*, have reported underutilizing formal health services specifically because they feel they are treated disrespectfully by health professionals. Similarly however, the second quote above by Medical Doctor 1 also refers to cultural differences such as “backwardness” to explain why indigenous community members refuse formal medical care.

The examples provided above indicate that while the medical doctors attribute underutilization of care to unwillingness and a lack of modernity, community members instead attribute underutilization to disrespectful treatment by health professionals. Whereas it has been interpreted that both community members and medical doctors mention cultural differences between indigenous Andeans and non-indigenous Andeans as an overarching cause. Accordingly, as the examples indicate, explanations of underutilization are mainly dependent on which group is being asked, with indigenous Andeans mainly citing disrespectful care and health professionals mainly citing unwillingness. Such contesting explanations of underutilization can be reflective of institutional discrimination. For example, because medical training is only available in urban areas where ethnic and cultural discrimination are an assumed part of everyday life, health professionals are trained in an environment where the predominant view is that underutilization of formal health services is mainly due to the different cultural beliefs and practices of indigenous Andeans and therefore changing health seeking

behavior when working in rural areas is the main focus (Altamirano et al. 2003). Consequently, poor treatment towards indigenous Andeans is already present in the health system and is continuously reinforced during medical training (Altamirano et al. 2003). Interestingly, community members who were asked whether they took any steps to minimize the poor treatment they felt from health professionals, generally agreed that speaking Spanish and ensuring their clothes, feet and hands were cleaned prior to health visits helped to decrease the sense of discrimination and occurrences of disrespectful treatment. Responses such as this can potentially be attributed to the process of *mestizaje* which assumes that emphasizing non-indigenous traits can reduce the risk of indigenous discrimination as discussed in Chapter 3, Section 3.3 and Section 5.3 of this chapter.

5.4.6.2 Recruitment and Retention of Health Professionals

Another institutional boundary identified in this study involves the recruitment and retention of health professionals in rural areas. The Ministry of Health's compulsory service programs for recruiting health professionals to rural areas has inadvertently resulted in low retention rates, thereby influencing the quality of health services (Gabrysch et al. 2009). This has been examined in numerous reports including, for example, Gabrysch et al. (2009) and the World Health Organization (2010a). Consistent with such previous research, poor quality of care due to low staff retention rates in rural areas has also been identified as a significant barrier to maternal health services in this study. One particular factor hindering the accessibility and acceptability of services as indicated by the data are unstable contracts and short lengths of service. This is demonstrated by the following quotes:

"I came to work in [Community 9] as part of my compulsory work placement. But this is almost up. I'm looking forward to going back to Cusco. It is so much harder to work properly up here. The community members don't always listen to us so I'd be happier working in an environment where I am more comfortable." (Medical Doctor 3)

"I have six children. I had five of them at home with the community health worker. But my last one, I had here [at the health center]. I did attend all of my prenatal checkups but those were at the health post. When I felt the baby was

coming, I went to the health post and then the ambulance took me down to [the town health center] to give birth to the baby. I was very scared because there were so many people, many nurses and I didn't recognize any of them from any of my previous visits...I would not want to go there again.” (Community Member 1)

The first quote above is an example of the providers' point of view. For this participant, working in a rural environment is not as preferable to working in an urban setting such as Cusco. Similar to many of the previous quotes presented in this chapter, this participant finds that the community members do not listen to the medical advice they are given. Alternatively, the second quote provides the point of view of a community member who did not feel comfortable surrounded by so many unrecognizable people at the health center. In this case, the community member expresses that the experience left her not wanting to go to the health center again. The high turnaround of staff at the health center can thus be interpreted as a problem for potential service seekers. Other examples of how high staff turnover might affect the quality and availability of care are provided by the following quotes:

“I don't know where I am going to be after next Christmas. My placement is up next year you see. That's what happens with the rural placements, they only last for a few months at a time...it doesn't leave me feeling very stable...Plus even though I always try to work hard, I don't feel like I am making as much of an impact as I would if I were in a city.” (Obstetrician 2)

“I didn't want to come out here to work initially, but this is where they [MINSA] placed me...I am from Cusco you see. I wanted to stay there to work. I find it harder out here because the people have different ways of life. You know, they are indigenous...they don't understand that childbirth needs to occur with a skilled doctor.” (Obstetrician 2)

The above two quotes demonstrate that job security (or insecurity) may be closely linked to job satisfaction and therefore the quality of care provided. Examples such as these can, for example, be interpreted to correspond to the ways in which health professionals carry out their work, thus potentially influencing their motivation to provide high quality health services. Further, shorter contracts would not likely foster greater understanding of the different health needs of the indigenous population, thus also influencing the quality of care provided. The second quote above, for example, seems to indicate that

the obstetrician feels her expertise is being underutilized. The obstetrician's expertise, however, is counter to the local belief system of the indigenous people. Moreover, as the data suggests, there is often little effort to integrate indigenous perspectives into biomedical perspectives, thus further detracting from the quality of care provided.

In addition to low retention rates, another institutional problem identified was the lack of experience of young health professionals placed in rural areas as part of the compulsory medical placements during training. This is indicated in the following quote:

“The doctor at the health post is very young you see. She is much younger than me and she doesn't have any children. In addition, she is from the city, she is not like us. How is she supposed to know what we are going through, what the women expect when they have their babies?” (Community Health Worker 6)

As the majority of health professionals working within the Peruvian Ministry of Health have to undergo compulsory placement into rural areas as part of their training, rural health professionals are often young and less experienced than urban or private practice health professionals. The above quote describes this CHW's opinion of some of the problems that may result from the young age and inexperience of the health post doctor. This is consistent with studies by scholars such as Frehywot et al. (2010) who have examined job efficiency among young rural doctors placed in rural locations. They explain that in South Africa for example, the inexperience of doctors sent to rural areas was believed to hinder the quality and timeliness of care. Other studies however, have also pointed out that the relative age difference and inexperience of student medical workers can potentially be valuable (Dolea et al. 2010). This may occur because such workers who are new to the health system might be more willing to try to improve health system inefficiencies specifically affecting rural areas (Dolea et al. 2010).

5.4.6.3 Valuing Maternal and Newborn Life

The final institutional boundary which was identified in this study concerns the way pregnant and postpartum women were treated by health professionals and health coordinators in relation to their newborns. Throughout data collection, it was observed

that some health professionals and health coordinators seemed to place greater emphasis on ensuring the care of the newborn over that of the mother. This was mainly evident in the ways in which maternal health services were carried out, in particular during childbirth and the postpartum. For example, the following quote made by an obstetrician describes her views that more emphasis is placed on child health, sometimes even at the expense of the mother:

“I do think that there should be more focus on the mothers. So that we can make sure both the mothers and the babies are safe. We just don't have a very large budget. Not much at all. And the money that we do get goes straight to programs for improving child health. Childhood nutrition is very important. But yes, we should be focusing more on teaching women about their own health, especially family planning.” (Obstetrician 1)

The same obstetrician was then asked to describe if she felt that postpartum care services for indigenous women in rural communities were being underutilized. The following quote provides her response:

“Not really, but it's hard enough to get them to come down for the childbirth, it would be even harder to expect them to come down once the baby is born. They have a few check-ups they are supposed to go to. We do visit them to make sure the baby is okay. After the first few weeks though, it's not really under our remit anymore. They have to make sure they are caring for their baby and themselves. We do go in and make sure that the baby is being breastfed and maintaining the proper weight...but then that's it. If they don't want to see us, well we still have to put our attention on the other pregnant women.” (Obstetrician 1)

An important issue which can be inferred from both these quotes is the apparent disengagement of responsibility towards the mother and infant after a few weeks following childbirth. Additionally, if postpartum care does occur, it is mainly to check if the infant is being properly fed and maintaining a proper weight, with less emphasis on the health of the mother and any potential postpartum complications. Disengagement of responsibility may be due to a number of reasons, such as lack of resources (e.g., transportation), time, or perhaps even the perception that they are not likely to make much of a difference given that some indigenous women may not be interested in the “modern” health care approach. This may be considered a further institutional barrier to

postpartum care, particularly as further findings from this study indicate that the newborn's life may be given higher value than his or her mother by health professionals and is entrenched in the design of the health system itself. The reason for this is not clear, but interestingly it may correspond to the progress of MDGs 4 and 5 in Peru, with MDG 4 having led to significant improvements in child mortality while MDG 5 still lags significantly behind.⁶⁷ Similar problems to those found in this study were cited in the study by Duysburgh et al. (2015, p.6) of rural districts in Burkina Faso, Kenya, Malawi and Mozambique, including:

Poor organization of services and quality of care, lack of knowledge in the community, and traditional beliefs and practices further delay or inhibit PPC [postpartum care]. Stakeholders and health workers reported understaffing, high staff turnover, poor motivation and lack of staff knowledge and skills on PPC...

Another example of how differing values of maternal and newborn health can be present as an institutional boundary is evident in the negative childbirth experiences of indigenous Andean women resulting from disrespectful care as described below:

"It wasn't the same as when I had my other children [at home]. In my community when women give birth, they handle the baby delicately. In the health facility they hold tight and pull hard. They were very rough with me... and it was a lot harder." (Community Member 1)

"They [hospital staff] were being very rough with me and hurting me a lot when I was in labor. They kept pushing on my stomach and I was very scared. They told me it was to keep the baby safe so that was okay, but they didn't seem to care about what I was feeling." (Community Member 1)

As indicated by the first quote for example, giving birth at the health facility was more distressful than previous experiences giving birth at home. When asked how this experience made her feel, the community member responded that she would have felt less fear if the health staff would have communicated with her more throughout delivery. It is possible for this experience to be interpreted as a form of institutionalized

⁶⁷ The target for MDG 4 is to reduce by two-thirds between 1990 and 2015, the under-five mortality rate. (World Health Organization 2010b). Currently Peru is on track to reach MDG 4, but not MDG 5 (Soe-Lin et al. 2014).

“obstetric violence”, where the predominantly western biomedical customs lead to the potential for maltreatment from health professionals due to different cultural expectations regarding maternal health and childbirth. Obstetric violence is a legal term which has been gaining popularity in Latin America and has been defined as:

...The appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert [sic] the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women. (Arnold 2010, para. 3)

The presence of obstetric violence can also be detected in the community woman’s second quote above where she explained that the health staff were not as attentive to the discomfort she was feeling and paid more attention to ensure the safe delivery of the baby. Obstetric violence has been discussed by several scholars in Peru, in particular since the forced sterilizations of the Fujimori regime as discussed in Chapter 3, Section 3.4.1 (Arnold 2010; Cripe et al. 2007). Accordingly, the observed correlation between the way health professionals place more emphasis on newborn life over that of the mother and maltreatment of Andean community members during the pregnancy period can potentially contribute to institutional boundaries to care.

The three factors presented in this subsection were observed to be entrenched within the structure of the health system. Consequently, they have been interpreted as posing significant challenges to delivering acceptable maternal health services, thus resulting in underutilization of formal health services in the study area. The social boundaries of exclusion, characterized by ethnic, cultural, gender, education, language and institutional barriers to care, were each shown to play a part in reinforcing the exclusion of the indigenous population from reaching acceptable maternal health services (see Figure 21: The social boundaries of exclusion for a diagram of the social boundaries of exclusion). The indigenous population is therefore impeded by inequality and uneven power relations constraining their opportunities for equal rights to quality health services. In this regard their differing social, ethnic and cultural identities reinforce powerful exclusionary processes that result in more limited rights to citizenship than the rest of

the population, namely the non-indigenous, thereby impeding access to equitable health care.

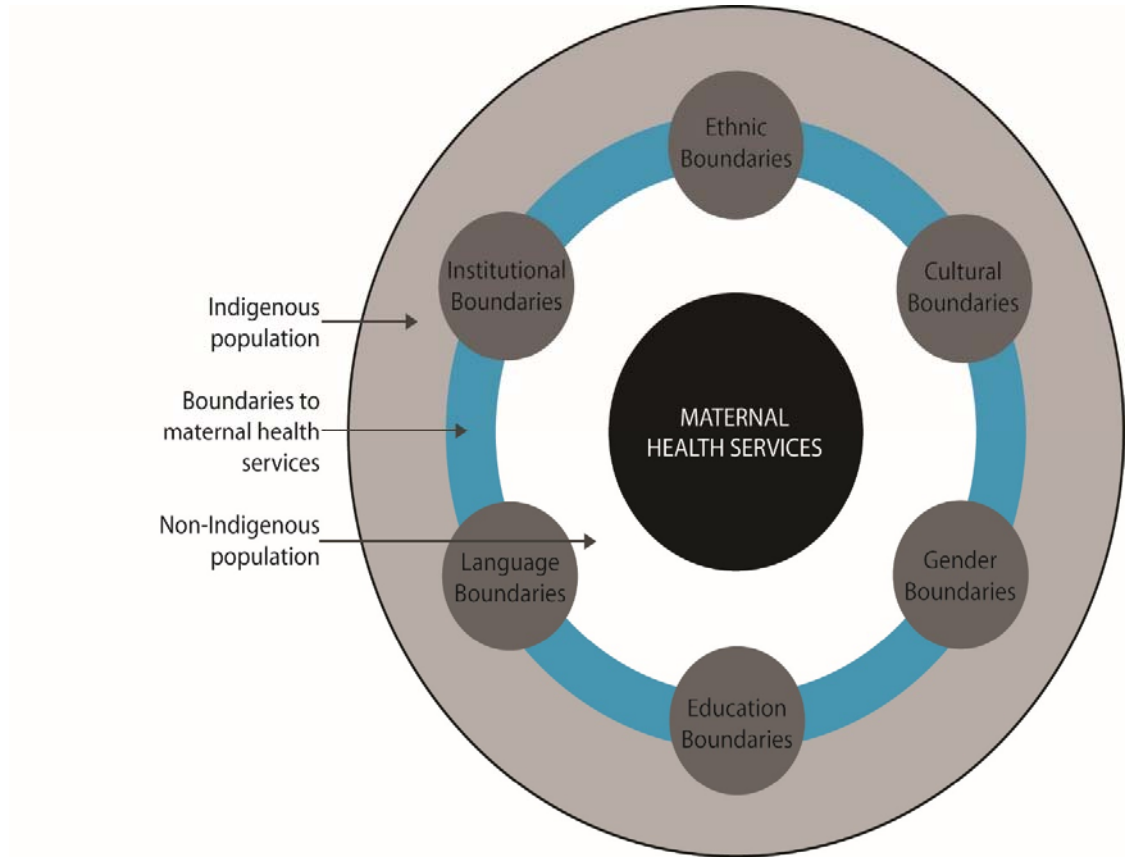


Figure 21: The social boundaries of exclusion

5.5 Health Service Relationships

The previous sections of this chapter have discussed the ways in which social identities and group membership can contribute to social and institutional boundaries to maternal health services in Peru's Andean communities. Using examples from the data, the remainder of this chapter examines how the five dimensions of the social identity approach can be used to explain the ways members of different social identity groups – specifically community members, CHWs and health professionals – interacted with one another. In accordance with Bourdieu's (1977) theory of symbolic power, as described in Section 2.2 of this thesis, findings from this study have indicated that positive or

negative interactions between different groups, in this case in terms of ethnic identity groups, closely correspond to uneven power relationships existing between them. Consequently, it was identified that negative interactions reflected by discriminatory attitudes often lead to the exclusion of the indigenous population. This was particularly evident in the power imbalance observed between community members as potential service seekers or users of maternal health services, and health service professionals as providers of care. While health service users and providers of care traditionally hold a power imbalance in terms of differing levels of authoritative knowledge⁶⁸ (Browner and Press 1996; Jordan 1977; Jordan 1993 [1978]; Ketler 2000), this study has found that perceived negative interactions between service users and providers of care are exacerbated when occurring in a context of extreme social and institutional exclusion. Accordingly, the final subsection of this chapter discusses how relationships between service users and providers are influenced by different social identity affiliations and how differing levels of authoritative knowledge between community members and health professionals can contribute to reinforcing uneven power relations, thus leading to continued exclusion from maternal health services.

5.5.1 The Patient/Provider Relationship

As discussed throughout this thesis, social and institutional exclusion hold a significant presence in Andean life. For indigenous Andeans seeking formal maternal health services, interaction with health professionals who predominantly belong to a different ethnic, cultural and professional identity group is inevitable. Given the various social and institutional boundaries to care, positive interactions with health professionals as described thus far were observed to be important for enhancing the utilization of formal health services. Despite this finding however, all of the community members spoken to or interviewed during this study recounted at least one negative experience if not more during interactions with health professionals. The predominance of negative interactions

⁶⁸ Authoritative knowledge is the view that there are multiple systems of knowledge where social processes legitimize the dominant, or more valid way of knowing while devaluing or dismissing the less valid (Jordan 1993 [1978]).

is particularly harmful to indigenous Andean women in need of maternal health services given their relative lack of autonomy as members of a doubly excluded group (i.e., indigenous and female) facing a non-indigenous health system within a largely patriarchal society. Further, with health professionals holding a position of authority during health care interactions, indigenous Andean women are in a position to lose even more autonomy over their own bodies as a result of power imbalances between themselves and the health professionals attending them. The following two quotes provide examples of how uneven power relations during health care interactions can be interpreted as contributing to women's loss of control over their maternal health choices:

“When it comes to getting [formal] maternal health care...I don't know very much but I do remember the young lady doctor said something to us about it. I think she said something about keeping track of our pregnancies. I didn't really understand though because she spoke in Spanish...I do remember she was abrupt with me though. But that is not uncommon..., to be abrupt, to be unkind....”
(Community Member 3)

“The obstetrician visited me earlier...she gave me vitamins to take for anemia, she said I need these because my baby might get hurt during the birth. Or me. This scared me so I have been taking the vitamins. But I didn't do this before...and what if I don't actually need them? What if they harm me instead?”
(Community Member 2)

Both of the above quotes describe instances where community women are left with uncertainty following interactions with health professionals. For instance, the community woman providing the first quote above describes not “know[ing] very much” about formal maternal health services and having to rely on the doctor for information. Further, the woman describes a negative experience with the doctor using terms such as “abrupt” and “unkind”, however she dismisses this as a common occurrence when interacting with health professionals. The seemingly automatic dismissal of the doctor's behavior toward her shows that despite feeling uncertain and experiencing disrespectful care, she is accustomed to accepting this treatment. The implication this can have is that automatic acceptance seems to result in normalizing disrespectful care, with the consequent result of reinforcing exclusion from health services.

In the second quote, the uneven power relationship between the community woman and the health professional is more implicit. The community woman for instance refers to being “scared” following her interaction with the obstetrician. She responds to this feeling by following the obstetrician’s advice and takes the vitamins despite not having done so before. Additionally, she questions whether the vitamins are necessary or even potentially harmful for her, however she continues to take the vitamins. Similar to the first quote, this quote indicates that maltreatment and feelings of uncertainty over medical advice are easily dismissed by community women and result from the assumed professional knowledge of health professionals, thus placing the health professional in a position of holding greater power over the women’s health choices. In both instances, the community members are seemingly accepting the authoritative knowledge of the dominant social group, which in this case are non-indigenous health professionals.

Of equal importance for this discussion is the potential for determining the possible benefits (and limitations) of applying social identity processes to explain positive or negative interactions between health seekers and providers. For example, the first three dimensions of the SIA: *1. Social Identity*, *2. Social Structure* and *3. Identity Content*, as defined in Section 5.3, can be useful for interpreting the above quotes. As the data suggests, community members and health professionals perceive themselves to belong to separate social identity groups given their different professional and social backgrounds.⁶⁹ These individual (e.g., community member, health professional) and group categorizations (e.g., indigenous Andean, non-indigenous Andean) reinforce the presence of “othering”, which equally reinforces the presence of the us/them dichotomy (Dimension 1). Discrimination from the health professional group toward the community member group can thus be interpreted as a result of negative connotations associated with indigenous identity. Accordingly, negative interactions leading to discrimination can also be interpreted as resulting from structural characteristics between groups (Dimension 2), which are also due to internalized group norms and

⁶⁹ For pragmatic purposes “social backgrounds” is used here to refer to the different social dimensions of the Social Boundaries of Exclusion such as ethnic, cultural, gender, education, language and institutional.

attitudes (Dimension 3). This is mostly evident in differences in status and power between lay community members and non-indigenous health professionals. Dimensions 1 through 3 are thus useful for providing meaningful social categorizations which explain how negative behavior based on identity association, can potentially lead to negative interactions, reflected by discrimination or structural violence.

It is important to note however, that this approach is subject to some limitations. For example, the SIA by its nature argues for the fluidity of identity categorizations (Dimension 5: Context), as evidenced by multiple social identity memberships at any given time. This thesis agrees with this notion of the SIA and argues that identity categorizations are indeed fluid, however the act of categorizing itself, and the resultant behavior reflected by categorizing, conflicts with this argument. Many of the above quotes for example seem to imply a homogenous identity (as can be noted by the us/them differentiations in particular). Fixed identity categorizations as implied in many of the quotes, can thus be problematic when interpreting data through an approach emphasizing fluid social identities. This will be examined further in the following chapter.

5.6 Conclusion

This chapter has described how social and institutional boundaries contribute to exclusion from maternal health services in the Andean communities of this study. First, a description of the study site and population was provided in order to set the context of the study. The ways in which the SIA has been used in this study were explained. This was predominantly to highlight the ethnic and cultural tensions arising from varying social identities and intergroup relations. Such tensions were observed to be deeply rooted in the social and historical experience of the indigenous communities, and as such, have influenced the lives of the Andean population and those working in the region. Findings from this study indicate that there may be a strong presence of differentiating between in-groups and out-groups, which can potentially reinforce occurrences of “othering”, consequently contributing to exclusion. As a result, this study

has identified six main social boundaries of exclusion: *ethnic, cultural, gender, education, language* and *institutional*. These boundaries were interpreted to act as catalysts for discrimination based on different group identities. Relationships between indigenous community members as potential health service users and non-indigenous health professionals as health providers were thus found to be under strain as a result of uneven power relationships between different identity groups, (e.g., indigenous community members and non-indigenous health professionals). The following chapter thus examines how the social boundaries of exclusion can further influence relationships between the different participant groups. Drawing from the findings outlined in this chapter, the following chapter provides a discussion of the influence CHWs may or may not have in facilitating interactions between these groups, thereby also influencing the way maternal health services are experienced and carried out in the study area.

Chapter 6: Crossing Boundaries for Maternal Health

6.1 Introduction

One of the aims of this study was to identify whether a substantive theory could be developed that could explain the ways in which CHWs may (or may not) be able to enhance the availability, accessibility, and quality of maternal health services in Cusco's Andean communities. To do so, the relationship between social identity – namely, ethnic identity – and social exclusion has been examined. As such, while the previous chapter presented the data and provided an analysis of the findings thus far, this chapter discusses the substantive theory which was developed as a result of this study. Drawing on these findings as well as relevant literature, the substantive grounded theory is intended to demonstrate the various identified roles of CHWs and discuss their potential importance as frontline providers of maternal health care in Andean communities of the Cusco Region of Peru. Following this introductory section, this chapter is divided into a further seven sections. Section 6.2 provides a brief overview of the substantive grounded theory. The theoretical categories leading up to the development of the substantive grounded theory are then examined. To begin with, Section 6.3 explains a basic social problem identified in the study area, that of intergroup tensions, which was determined to be a main component of Andean exclusion. Section 6.4 describes some of the sources of intergroup tensions contributing to Andean exclusion. Section 6.5 then discusses the central concept of boundary crossing as it has been used in this study. Accordingly, this section provides an analysis of whether the processes of adopting an informal professionalized identity combined with ethnic bargaining may be utilized as a way to facilitate social mobility and possibly overcome exclusion from maternal health services. Section 6.6 thus explains how bargained identity may be used as a means to enhance maternal health service relationships. The final section (6.7) concludes this chapter.

6.2 The Grounded Theory: Crossing the Social Boundaries of Exclusion through Enhanced Social Mobility

The substantive grounded theory which was developed from this study offers a theoretical interpretation of the social processes contributing to and resulting from indigenous exclusion in Andean communities of Cusco. Consistent with Charmaz' (2006) constructivist grounded theory approach, this theory attempts to understand *how* the participants of this study construct and view their social worlds and experiences in order to understand *why* they might take the various actions that they take (e.g., discriminating against other social groups or avoiding maternal health encounters due to expected discrimination). Subsequently, an analysis of the responses of the five participant groups has highlighted hierarchies of power, communication and social status that are embedded in the societal norms of Andean life. For instance, investigating the experiences of service users, providers and coordinators of Peru's rural maternal health services has demonstrated that deeply entrenched ethnic tensions are often present among the groups. Of particular importance to this study has been the identification of potential ways to cross, or enable others to cross, or maneuver between the social boundaries of exclusion contributing to the inaccessibility or unacceptability of maternal health services. Analysis of the study findings has demonstrated that Andean CHWs, through their status as both community members and lay health workers, can have ties to both the local community as well as the formal health system. Having this "dual"⁷⁰ social identity resultantly places CHWs in a unique position to act as "boundary crossers", or individuals who are enabled to cross between conflicting environments (e.g., indigenous communities and "western" style health facilities), thereby potentially facilitating interaction and creating links between different ethnic or social groups, such as ethnically indigenous Andean community members, and ethnically *criollo* or *mestizo* health professionals, who might otherwise avoid interaction with one another. This raises the questions, however, of whether or not CHWs can actually take on the role of

⁷⁰ Dual social identities occur when individuals view themselves as members of different groups working toward the same goals (Dovidio et al. 2005).

boundary crossers to enhance maternal health service relationships, and if so, what necessary factors need to be in place for CHWs to play this role?

Accordingly, the substantive theory constructed from the study findings places CHWs at the focal point of understanding if the boundaries of social exclusion can potentially be “crossed” through the facilitation of increased social mobility. It has been identified that increased social mobility by CHWs can likely happen as a result of the negotiation of one’s social identity, in this case through the adoption of a professionalized identity. Indigenous community members who become CHWs, for instance, may undergo a transformed social identity (e.g., indigenous community members with a professionalized identity) which could then allow them to have a presence in multiple social environments (i.e., multiple social groups), such as the community member group, as well as lay members of the health professional group. Drawing on social constructionist research that discusses the existence of multiple selves, with each “self” being entirely context-dependent, this theory identifies CHWs as an informally professionalized social group⁷¹ incorporating multiple fluid social identities (e.g., indigenous, Andean, community member, lay health worker, health professional), and thus exhibiting behavior associated with each “self” (Hogg and Vaughan 2008). This transformed social identity inclusive of a professionalized identity has a number of implications for individual self-identity, and can in turn potentially influence one’s group identity and therefore individual and group behavior or social status. For example, incorporating a professionalized identity generally associated with *mestizo* or *criollo* identity (i.e., health professional) into the social identity of indigenous Andean community members, who are traditionally excluded from the rights of social citizenship, (as explained in Section 3.3), can possibly have an influence on one’s personal confidence, thus leading to feelings of empowerment. This is certainly not to say that one identity is presumed better than another, however, as will be explained in

⁷¹ The professionalized identity of the CHWs are identified as “informal” because the CHWs in this study are not required to undergo a rigorous training and qualification process as normally expected from other “formal” professional identity groups. This will be explained more fully in Section 6.5.1 of this chapter.

Section 6.5.1, professional identities are highly valued in Peruvian society and often carry added opportunities for increased social status. Consequently, an assumed professional identity may result in the CHW being perceived as an authority figure or agent of change within their communities, capable of challenging societally entrenched power imbalances (such as the exclusion of indigenous community members from quality maternal health services). In this regard, CHWs would not just be lay health professionals, but would also be empowered to act as community representatives, thus adding another important component to their social and professional identities.

Conversely, adopting a professionalized identity may also result in indigenous Andean community members disengaging with their original community member identity as a way to reap the potential advantages of having stronger ties to the group with more social rights and opportunities, and thus power (i.e., the health professional group). Disengaging from one group in order to cross into the more “advantageous” group, however, could have the unintended result of not fully fitting into either group, thereby possibly creating yet another social boundary. Adopting a professional identity can therefore either facilitate movement between different social groups, or contrarily result in alienating oneself from the original social identity group, while at the same time not being fully accepted into the more advantageous group.

The substantive theory has therefore been constructed to provide an interpretation of which factors need to be in place for a CHW to assist Andean community members to negotiate the social boundaries of exclusion. Given the prominence of health inequalities resulting from ethnic based discrimination, emphasis has been placed on examining the specific factors that can facilitate maneuvering between ethnic boundaries.

Consequently, in addition to adopting a professionalized identity, the process of ethnic bargaining has also been identified as a critical mechanism for negotiating exclusionary relationships.⁷² The idea that CHWs have a greater chance to maneuver from an ethnically excluded group (i.e., indigenous community members) into a non-excluded

⁷² The concept of ethnic bargaining will be defined in Section 6.5.

group (i.e., health professionals who are not ethnically indigenous) by adopting the professionalized identity of the group with more rights to citizenship, could have important implications for improving maternal health services in areas where ethnic discrimination and health inequalities play such an integral part in the exclusion of indigenous Andean community members in need of services. For example, if the necessary factors for boundary crossing are thus met, CHWs may have the potential to significantly influence indigenous community members' usage of formal maternal health services. Equally, through interaction with members of the formal health system, CHWs might also be able to relay the concerns of the community to health professionals and coordinators of care, thus also potentially influencing the quality of maternal health services. However, if boundary crossing is not successful, then CHWs may face rejection from either community members or the health system, thus leaving them outside of the boundaries of either group. Understanding whether CHWs can be enabled (or enable others), to successfully maneuver between groups bounded by uneven power relations, without creating additional exclusionary boundaries, is thus important for understanding the extent to which CHWs can successfully play the role of boundary crosser in order to facilitate interaction between health service users, providers and coordinators of care. The challenge thus lies in identifying which factors need to be in place for CHWs to successfully maneuver, or enable others to maneuver, between both groups in order to enhance the availability, accessibility, and quality of maternal health services.

In summary, the key points of the substantive theory are listed below:

- Community members who also identify as CHWs may undergo a transformed social identity inclusive of an informalized professionalized identity.
- Feelings of empowerment and self-confidence due to having a professionalized identity may result in the CHW being perceived as a community representative or agent of change within their communities.
- The incorporation of a professionalized identity which is traditionally associated with greater rights to social citizenship (and therefore increased opportunities to

challenge societal norms) may facilitate movement between social groups (i.e., social mobility).

- Combining the adoption of a professionalized identity of CHW with the process of ethnic bargaining may be a useful mechanism for negotiating exclusionary relationships in settings where ethnic boundaries persist.
- However, disengaging with the original social identity group may result in becoming alienated from that group while simultaneously not being accepted into the more advantageous group, possibly resulting in creating yet another boundary.
- If boundary crossing is successful, CHWs may have an increased opportunity to create links between community members, health professionals and health coordinators (e.g., through communication or shared experiences), thus potentially leading to increased utilization of formal maternal health services.
- In order for CHWs to make the most of their potential role as boundary crossers, certain factors need to be in place to enable the negotiation of exclusionary power relationships.
- Identifying these factors is thus central to understanding whether CHWs can act as boundary crossers in order to alleviate exclusionary relationships.

To arrive at this theory, seven theoretical categories were developed during the analysis phase of this study: 1. *Feeling internal conflict*, 2. *Being influenced by assumptions*, 3. *Adopting a professionalized identity*, 4. *Bargaining ethnic identity*, 5. *Being empowered*, 6. *Negotiating trust*, and 7. *Facilitating interactions*.⁷³ Each of the theoretical categories was developed as a result of identifying intergroup tensions based on uneven power relationships to be a basic social problem in rural Andean settings. The presence of intergroup tensions seemed to be deeply entrenched in the social interactions between the different participant groups, specifically during patient/provider encounters.

⁷³ As discussed in Chapter 4, Section 4.11.1.1 and consistent with Charmaz (2006) and Glaser (1978), this study uses gerunds in coding in order to ensure the focus is placed on actions and processes rather than descriptions.

Consequently, coping with these tensions seemed to be perceived by the participants and author of this study as a common aspect of daily life. As such, the basic social problem was labelled: “*Coping with intergroup tensions*” and is discussed in Section 6.3. An analysis of the types of intergroup tensions and potential reasons for these resulted in the development of the first two theoretical categories: “1. *Feeling internal conflict*” and “2. *Being influenced by assumptions*”. The internal conflict referred to in the first category pertains to the apparent conflict that an individual may experience over feelings of individual, group and national pride in indigenous affiliation, while at the same time associating indigenous affiliation with exclusion and discrimination. The author has interpreted this internal conflict as an occurrence which influences individual behavior, such as choosing which social identity to emphasize given the particular circumstance in question. Views such as these were discussed by participants from each of the participant groups and will be examined in Section 6.4.1 of this chapter. The second theoretical category discusses how individuals may be influenced by the assumptions they hold over the expected behavior of the different participant groups toward each other, and thus act on these assumptions. Such assumptions were interpreted as a leading contributor to the intergroup tensions experienced among groups. This is discussed in Section 6.4.2 of this chapter.

The substantive grounded theory titled: “*Crossing the Social Boundaries of Exclusion through Enhanced Opportunities for Social Mobility*” was then developed following the identification of the basic social problem and two categories above (Section 6.5). Further analysis of the data thus led to the construction of a third and fourth theoretical category. These were labelled: “3. *Adopting a professionalized identity*” and “4. *Bargaining ethnic identity*”. Category 3 was developed in response to findings from the data indicating that the adoption of a professionalized identity, such as CHW, could potentially enhance a person’s confidence and feelings of empowerment, and thus facilitate boundary crossing. Category 4 was developed to explain how ethnic bargaining might also enable CHWs, or allow CHWs to enable others, to cross boundaries through similar feelings of empowerment.

Section 6.6 discusses these categories in the more specific context of maternal health services. This section explains how bargained identity may be utilized to facilitate interactions between community members, health professionals and coordinators of maternal health services. Accordingly, the final three categories were developed to explain three important factors identified as essential to utilizing bargained identity as a form of social mobility. The final three categories were respectively labelled: “5. *Being empowered*”, 6. *Negotiating trust*”, and “7. *Facilitating interactions*”, and are discussed in turn. The theoretical categories leading to the development of this substantive grounded theory are presented visually in Figure 22 below and will be discussed throughout the remainder of this chapter.

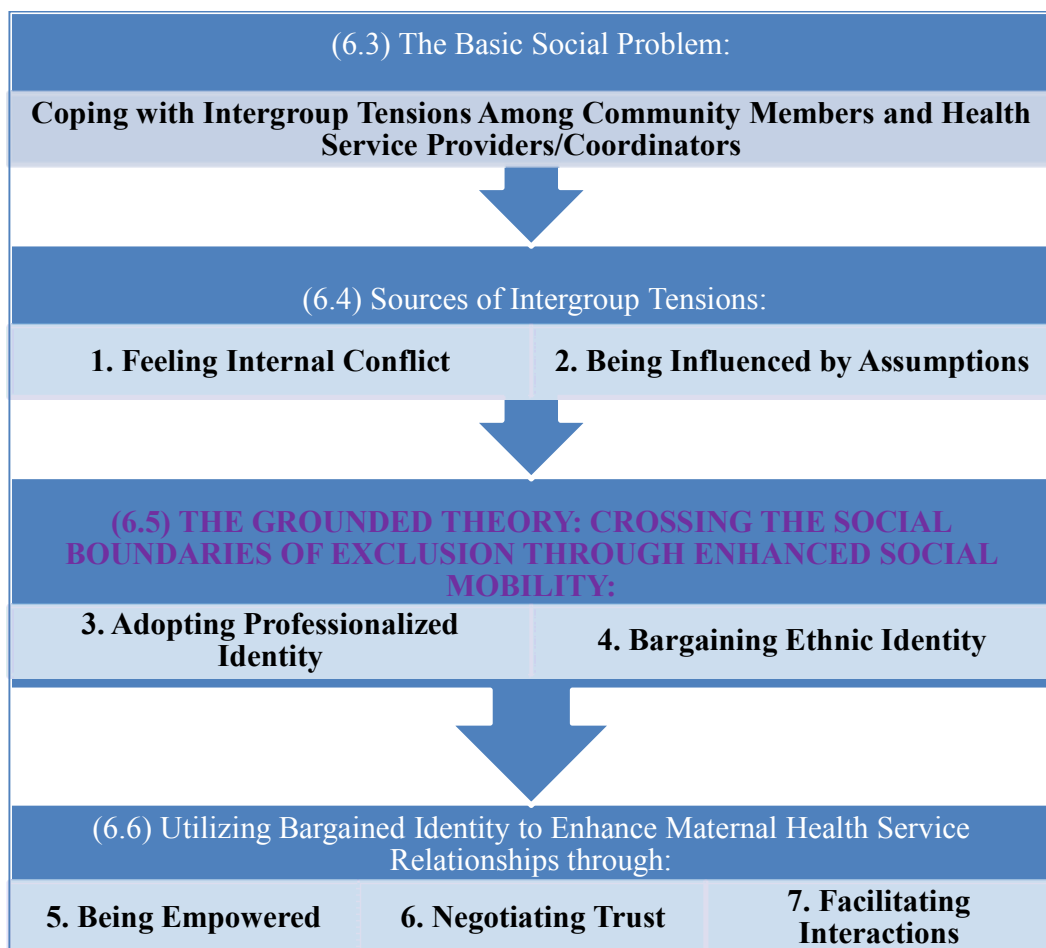


Figure 22: Theoretical categories of the substantive grounded theory

6.3 The Basic Social Problem: Coping with Intergroup Tensions

The substantive grounded theory was developed following the identification of a basic social problem contributing to the exclusion of indigenous Andeans from accessible and acceptable maternal health services. The deeply rooted presence of intergroup tensions between different ethnic groups throughout the country has been debated frequently and extensively among numerous scholars (Altamirano et al. 2003; Beall and Piron 2005; Castel 1998; D'Andrea 2007; Figueroa and Barrón 2005; Garcia 2005; Paredes 2007; Torero et al. 2004; Van den Berghe 1977). As discussed in Chapter 3 of this thesis, much of the literature and dialogue concerning divides between different social groups often deny the existence of racist practices in Peru. Consequently, the tendency to dismiss racism against indigenous Peruvians as resulting from cultural differences rather than ethnic differences continues to characterize the national ideology (de la Cadena 2001). As such, the substantive theory developed from this study attempts to explain how racist actions influenced by ethnic discrimination may indeed exist, however they are likely characterized by a combination of both cultural and ethnic differences between groups, specifically between indigenous Andean community members as potential health seekers, and non-indigenous health providers and coordinators of maternal health improvement programs. By examining participants' responses towards experiences of ethnic discrimination while using maternal health services, this study was able to identify how behaviors towards different social identity groups, traditionally characterized by uneven hierarchies of power, communication and status, are sometimes influenced by their expected relationships with each other. Accordingly, the basic social problem of coping with intergroup tensions demonstrates that some pre-conceived judgments about different groups and group members might be exhibited by certain behaviors, such as community members avoiding interaction with health professionals, or health professionals treating community members as inferior. Similar to findings from previous studies (de la Cadena 2001; Garcia 2005), the presence of intergroup tensions in the study area seem to be so ingrained in daily life that many participants exhibited an apparent attitude of acceptance toward ethnic based discrimination. This acceptance of discrimination as just a "normal" part of daily life, reminiscent of Fanon's (1964)

concept of “alienation”, was interpreted to contribute to the underutilization of necessary maternal health services. Fanon’s definition of alienation (1964, p.38), for example, states that

...the racialized social group tries to imitate the oppressor and thereby to deracialize itself. The “inferior race” denies itself as a different race. It shares with the “superior race” the convictions, doctrines, and other attitudes concerning it.

Negative experiences in interactions with members of different ethnic groups in a health care setting are hence often expected and therefore also often taken for granted as “normal”. This will be discussed in more detail throughout this chapter following the subsequent explanation of how ethnic discrimination was interpreted to result from intergroup tensions between would be patients and providers of care.

As ethnic discrimination and intergroup tensions continue to present themselves in primary care settings in Peru and worldwide, social research into the experiences of health seekers and primary care providers has become a significant research focus (Amnesty International 2009a; Amnesty International 2009b; Bristol 2009; Mathieson et al. 2008; Silva and Batista 2010). Among the disciplines examining general discrimination (i.e., not specific to ethnicity) in the health services are those within the social and health sciences (e.g., anthropology, sociology, nursing). Nursing theorists in particular, have developed a strong literature base on the interactions between health seekers and providers, namely through an examination of the interpersonal relationships occurring between patients and primary level nurses (Carr 2001). While the participants included in this study represent both patients and nurses, as well as other cadres of health workers and social service providers, the literature offered by nursing science presents an advantageous starting point to discuss the intergroup tensions between indigenous community members seeking care and health professionals as providers of care.

In healthcare, interpersonal relationships have long been identified as a vital component of patient-provider interactions (Orlando 1961; Peplau 1952; Travelbee 1966). Defined

as social associations, affiliations or connections between two or more people, interpersonal relationships occur as a result of social interactions, and thus form the basis of social groups (Berscheid 1999; Berscheid 1999). Further, they are dynamic systems which may be based on varying fluid levels of relatedness, connectivity or solidarity (Berscheid 1999; Berscheid 1999). Different types of interpersonal relationships can, for example, be categorized by friendship, kinship, romantic or professional ties, and can last any length of time, from brief to life-long (Berscheid 1999; Gastmans 1998; Peplau 1952). Accordingly, drawing from early nursing literature, Peplau (1952) developed an interpersonal relationship theory in which the foundation of nursing practice is centered on the relationship between nurses and patients. The conceptual framework advanced by Peplau, emphasizes, above all, the need for a partnership between patients and nurses. This partnership, as she describes, is one which is based on shared experiences between the interacting parties. This is in contrast to the assumption that patients should passively accept treatment on the one hand, or that nurses should passively act out the orders of higher level health professionals on the other. As demonstrated in Section 5.5 of the previous chapter, the different participant groups of this study (e.g., indigenous Andean health seekers and non-indigenous health providers) do not usually have shared experiences in terms of ethnic discrimination. Peplau's theory can thus be useful to understand why partnerships are needed between health seekers and providers in order to minimize the likelihood of tensions occurring during health visits. For example, lacking a shared ethnic experience, and thus lack of partnership between groups may be reflected by power hierarchies based on social identity affiliation between care seekers and providers.

There are limitations, however, in applying this theory to populations with a history of ethnic based social exclusion. Fostering partnerships between patients and providers can be more likely in settings where potential patients have greater access to knowledge about their own health, and thus an increased likelihood of having shared experiences to build partnerships on (Kreindler et al. 2012). This would indicate that a degree of equality would be needed between the two parties in order to minimize the level of

authoritative knowledge held by the providers (Browner and Press 1996; Jordan 1993 [1978]). In Andean communities, the indigenous population is already largely excluded with often limited shared experiences between indigenous and non-indigenous groups, thus likely further limiting the potential for a partnership to be built between patients and providers. Consequently, indigenous Andean community members in need of maternal health services must somehow cope with these existing intergroup tensions in order to seek formal health services.

The basic social problem of coping with intergroup tensions is thus the starting point from which the substantive grounded theory developed. In societies where exclusion is commonplace, such as in the field site of this investigation, tensions between different ethnic and cultural groups can be better understood through a close examination of interpersonal relationships and the ways in which they may influence intergroup behaviors (Kreindler et al. 2012). As integral aspects of social groups, understanding the processes by which interpersonal relationships are formed and occur is useful for researchers seeking to examine social interactions between different social groups (i.e., intergroup behavior). Intergroup behavior, as defined by Hogg and Vaughn (2008, p.392) refers to behaviors which are “regulated by those individuals’ awareness of and identification with different social groups.” The interpersonal relationships encountered in this study have thus been analyzed in the context of understanding these intergroup processes, or more specifically the influence each person’s ethnic identity and behavior may exert on those he or she interacts with. Accordingly, the following section examines potential sources of intergroup tensions as identified in this study.

6.4 Sources of Intergroup Tensions

As a result of identifying the basic social problem as discussed above, two theoretical categories were developed to explain how participants perceived and reacted to the intergroup tensions they experienced. These categories were labelled: “feeling internal conflict” and “being influenced by assumptions”. The first of these theoretical categories describes the apparent internal conflict participants seemed to exhibit when asked to

define their own ethnic identities. This internal conflict was interpreted to result from some identity labels, such as *indigena* or *indio* being more associated with social exclusion while terms such as *mestizo* and *criollo* were more often linked to greater rights to social citizenship (such as through greater economic or social opportunity). The second theoretical category builds on the first and explains how assumptions about other social identity groups might foster group stereotypes and influence intergroup behavior. The elements of these categories are discussed in turn in the following subsections.

6.4.1 Theoretical Category 1: Feeling Internal Conflict

The theoretical category “feeling internal conflict” was developed while analyzing the relationship between the different social identity labels participants used and their experiences with discrimination. As described in the previous chapter, the data demonstrated that participants exhibited signs of emphasizing or de-emphasizing some social identity labels over others depending on the context of the situation. For example, indigenous Andeans with mixed ancestry would sometimes emphasize their *mestizo* identity over pure indigenous identity when visiting urban areas or interacting with non-indigenous Andeans in urban settings. Similarly, indigenous Andeans may have chosen to de-emphasize their indigenous heritage if they associated this with negative experiences. At the same time, however, the same Andean community members who indicated feeling shamed by their indigenous identity in urban settings, also expressed feeling pride in their Andean heritage and customs (See the following quote for an example from the data).

“I identify myself depending on how I’m treated. I am proud of my heritage and of my customs. Sometimes though, it is hard. Sometimes I’m treated badly. I teach my children to be proud [of their heritage] but at the same time, I know they will have less...” (Community Health Worker 1)

The decision to identify oneself depending on how he or she is treated could imply that although an individual may experience positive feelings (such as pride) over his or her indigenous heritage, the same person may choose (either consciously or subconsciously) to de-emphasize this in order to avoid being treated badly by others. The possibility for

individuals to experience “internal conflict” could therefore be reflected by the cognitive process of deciding which identity to emphasize or de-emphasize, or equally, which ethnic identity to show greater strength of identification to depending on the expected outcome.

The above interpretation is derived from constructivist notions of comparative ethnicity, specifically, those established by Norwegian anthropologist Frederik Barth (1969). Breaking away from older objectivist perspectives of ethnicity, such as “primordialism” which viewed ethnic membership as a characteristic acquired through birth, Barth instead considered ethnicity to be a social process based on practices of classification and categorization (Brubaker et al. 2004; Wimmer 2008). In other words, as explained in Chapter 3, Section 3.3, ethnicity is much more complex than a static ancestral connection. It is instead viewed as “the product of a social process rather than a cultural given, made and remade rather than taken for granted, chosen depending on circumstances rather than ascribed through birth” (Wimmer 2008, p.971). Under this view, ethnicity is defined in terms of the “...participants’ beliefs, perceptions, understandings, and identifications...[leading to]...an increasing concern with categorization and classification” (Brubaker et al. 2004, p.31).

The concern with categorization could thus reflect the presence of individual cognition in determining how ethnic identity is made sense of. If categorization is fundamentally a mental process, as scholars such as Lakoff (1987) have argued, then categories, as such, are employed in order to structure and order the natural and social worlds. The decision to emphasize or de-emphasize a particular ethnic categorization highlights the fluidity of ethnicity, thereby pointing to the possibility of an individual ascribing to multiple categorizations, or multiple selves. An internal conflict could thus arise if such categorizations result in conflict. For example if one categorization (e.g., indigenous) leads to an expected negative outcome, such as experiencing discrimination, then a cognitive decision making process weighing the “fitness costs and benefits”⁷⁴ may

⁷⁴ Fitness costs and benefits refer to the evolutionary psychological perspective that human cultural adaptations occur as a result of weighing the potential contributions or losses of a specific trait towards

occur. In this case, a negative outcome such as discrimination (i.e., costs) would be more detrimental to achieving equal citizenship than a positive outcome (i.e., benefits), as would occur if one were socially accepted into the more advantageous group (Barkow et al. 1992; Kurzban 2001). As such, ethnic categorizing may feasibly occur as a strategically power driven action dependent on the expected outcome.

Non-indigenous Peruvians similarly demonstrated ways that cognitive decision making over one's identity might lead to feelings of internal conflict. Evidence from the data as interpreted in this study, for example, shows how perceptions of Andean discrimination might also lead non-indigenous Andeans to de-emphasize any association they may have with Andean ethnicity. For instance, despite feeling pride in being historically connected to Andean ancestry as one participant reflects below, an individual with a less indigenous appearance (e.g., whiter skin) would quickly refute identifying as ethnically indigenous. In addition to biological attributes such as skin color being associated with discrimination, participants also referenced connections between feeling pride in the country's history and ways to raise tourism income.

"...What happens is, in this country we are all proud of our history. As you know, some of the biggest revenues in this country are made by selling this history for tourism. But then at the same time, anybody who has brown skin is discriminated against... We are all proud to talk about the history of our country, but ask someone whose skin is whiter than his neighbor if they are ethnically related to these ancestors and he will very quickly deny this" (Medical Doctor 3)

This highlights the potential for commodifying indigenous identity, which could thus be interpreted as another example of the pragmatic use of fluid ethnic identity categorizations. As Chapter 5, Section 5.2.1 describes, symbols of national identities linked to Cusco's historical past (e.g., llama figurines, handmade textiles or costumes of indigenous dress) are frequently used as a way to market indigenous cultural products. Accordingly, indigenous identity representations are given a monetary value and are

reproductive success (Barkow et al. 1992). In this case, reproductive success refers to the capacity an individual has for attaining equal rights to citizenship, and therefor surpassing exclusion.

thus related to practices of consumption. At the same time however, the same people who may be benefiting from commodifying “indigeneity” would also deny any sort of ethnic association. The term “commodification”, in the Marxist sense as it is used in this study, refers to the transformation of goods, services or ideas into a commodity (Marx 1986 [1859]). More simply, a commodity can refer to a product or activity produced by people and given economic value. In this case, Andean identity in the study area is perceived to hold value and thus utilized by various actors to achieve different means. Indigenous and non-indigenous Andeans for instance may choose to emphasize their Andean ethnicity to promote tourism income while simultaneously disassociating themselves from Andean ethnicity if they are in a situation where this might lead to discrimination.⁷⁵ Consequently, an individual making the decision to utilize indigenous identity as a commodity while distancing him or herself from this same identity, may be indicative of a cognitive decision making process where the individual experiencing internal conflict must again weigh the fitness costs and benefits of which identity to emphasize or de-emphasize, also depending on the context.

6.4.2 Theoretical Category 2: Being Influenced by Assumptions

As is common in grounded theory, the second theoretical category was developed concurrently with the first. While analyzing the data, it became apparent that participants often considered discrimination and exclusion against the indigenous population to be grounded in stereotypes or preconceived assumptions held by the different groups. Such assumptions, in turn, were viewed to reinforce power imbalances between groups. Stereotyping, as discussed in the social psychology discipline, refers to the cognitive, often subconscious component of how different social identity groups behave towards each other (Burgess 2003). As such, rather than being an individualistic personality-based trait, stereotyping is group based and highly prevalent in human societies. Accordingly, Brubaker et al. (2004, p.39) define stereotypes as “...cognitive structures that contain knowledge, beliefs, and expectations about social groups”. The practice of

⁷⁵ See Hogue (2008) for examples of other forms of commodification which have informed the development of this theoretical category.

stereotyping, or behaving towards others in a way that is influenced by assumptions over how others are expected to behave seemed to occur frequently among the study participants. For example, some participants that did not self-identify as ethnically indigenous often expressed the view that most Andean community members are uneducated and therefore misinformed about “correct” health care practice as indicated in the following quote:

“I know there are some community members who are educated enough to know when to go to their prenatals or to the doctor. For the most part though, they are uneducated. They are misinformed about a lot of things, like we are trying to harm them or take advantage of them. This false information spreads through the communities. I am always surprised when I meet a community member that knows the right things about health care.” (Municipal Worker 2)

Here, similar to the discussion presented in Chapter 2, Section 2.4, differences in what are considered “correct” health care practices highlight the tendency to privilege biomedical belief systems over traditional health and illness practices. Accordingly, indigenous community members who may not be as aware of biomedical health practices often have greater awareness over traditional Andean practices. This is not to say that one practice is more valid than the other. Indeed, as Chapter 2 has described, maternal health experts consider biomedical care to be very necessary for managing obstetric risks. However, assumptions such as these reflect how a dominant group’s ideology (i.e., those who subscribe to biomedical health systems) can reinforce the notion that the less-dominant group’s knowledge system is inadequate or not as valid, thus contributing to the exclusion of the less-dominant group (Berkes and Kislalioglu Berkes 2009; Swazo 2005).

Conceptualizing stereotypes can thus be useful for understanding macro level processes such as exclusion, in that they can be used to categorize others in terms of the social group they belong to. As Brubaker et al. (2004, p.39) explain, “like other categories, stereotypes are represented in the mind through some combination of prototypical features, concrete exemplars, expectations, and theory-like causal knowledge”. As such, stereotypes, like other social objects, are products of shared culture and can thus subtly

influence the way people perceive and judge one another and in turn behave toward one another (Brubaker et al. 2004).

Though often inevitable and pervasive in human societies, stereotypes, can also be problematic (Burgess 2003). In the case of this study, much of the discriminatory behavior between different social groups, in particular non-indigenous and indigenous groups, was interpreted to occur as a result of negative stereotyping; that is, holding negative assumptions towards others. As Burgess (2003) explains, negative stereotypes occur when one person within a group assumes another person from another group might be deceitful, or possibly aggressive. In consequence, the first person might respond deceitfully or aggressively towards the other person based on these assumptions, resulting in discrimination against the “out-group” member. Treating out-group members in a discriminatory manner in response to one’s (perhaps wrong or untested) assumptions, such as whose health care model may be more valid or refusing biomedical care due to differing cultural practices, for example, was thus also interpreted to be a dominant source of intergroup tensions for the study participants. This is because the negative discrimination resulting from the stereotyping of indigenous Andeans, combined with the internal conflict experienced in deciding which social identity to emphasize or de-emphasize depending on the perceived fitness costs or benefits of achieving equal citizenship status, may perpetuate the already present exclusion of indigenous Andeans. Consequently, assumptions based on culturally specific cues may reinforce ethnic based discrimination toward predominantly excluded groups, such as indigenous Andean community members. The following section thus discusses examples of how excluded community members might be able to temporarily step out of exclusion and move (somewhat) freely between different (ideally less-excluded) social identity groups.

6.5 Boundary Crossing for Social Mobility

The third and fourth theoretical categories, “adopting a professionalized identity” and “bargaining ethnic identity” were developed in conjunction with the identification of

“boundary crossing” as an important factor in potentially facilitating social mobility. These theoretical categories were equally identified as important components of boundary crossing for social mobility and will be discussed in turn in subsections 6.5.1 and 6.5.2. First, however, it is necessary to explain what is meant by boundary crossing. This sociological concept, as introduced in Section 6.2, is used to refer to individuals or groups who have the means and capacity to move freely across multiple social fields (Kilpatrick et al. 2009). More specifically, as Kilpatrick et al. (2009, p.286) explain, the term “boundary crosser” can refer to:

...people who live in the rural community and are employed in the health system and so are able to use the lens of a community member to analyse and lead actions to build and use community capacity for health development. They can do this because they operate in, and across, two or more social fields, including health. Boundary crossers have variously strong and weak ties with people in both the community and health fields. They have the potential to operate as opinion leaders...in a social network...[who]...can trigger alignment of behaviour or attitudes among other weakly equivalent people...who are similar but loosely connected and share their social networks.

Accordingly, indigenous Andean CHWs have the potential to act as boundary crossers because they are involved in multiple social fields and belong to at least two different social identity groups. As both community members and frontline primary care providers, they are in the position to gain trust from their fellow community members on one hand, and from actors operating within the formal health system on the other. In their role, CHWs operate between traditionally opposing and bounded systems of health delivery, such as traditional models of care preferred by indigenous Andean community members, and biomedical models of care preferred by formal health professionals. The potential for CHWs to cross boundaries, (thereby possibly enabling others to cross boundaries) has important implications for the varying social boundaries of exclusion discussed in Chapter 5. This section draws from that discussion and furthers the argument that CHWs, as community members with a specific professionalized identity and therefore members of both the community as well as the formal health system, are placed in a unique position to act as opinion leaders in order to cross both physical and social boundaries, in particular those which exclude indigenous Andean community

members from reaching equitable and acceptable maternal health services. Having the opportunity to act as an opinion leader may therefore enable CHWs to move between social fields, such as between the community and health field in order to “broker information flows between groups from positions on the edge of groups” (Kilpatrick et al. 2009, p.286).

To define the boundaries in question (i.e., the social boundaries of exclusion), and how these may be crossed, this section discusses the concept of communities and how they are bounded both by geographic localities, termed “*communities of place*” as well as by shared social practices based on shared experiences, termed “*communities of practice*”. A “community of place”, as Cheers et al. (2007, p.7), explain, a “...has a space, or geographic territory that is given meaning, or ‘constructed’ by its people” (Chenoweth and Stehlik 2001; Mormont 1990). This is described more fully in the following passage by Kilpatrick et al (2009, p.285):

Communities of place have both horizontal and vertical ties...There are two kinds of horizontal ties: internal links between people, groups, and organisations within a community, such as a hospital board and a general medical practice; and external links between these and neighboring communities, for example, the rural hospital and a larger one in a regional centre. Vertical ties...link a community’s people and organizations vertically to institutions and structures of the wider society. These include, for example, links between a hospital and the state health department...Horizontal ties are important for successful collective action by local people, whereas vertical ties connect them with external resources and power centres. (See Figure 23 for a visual representation of communities of place)

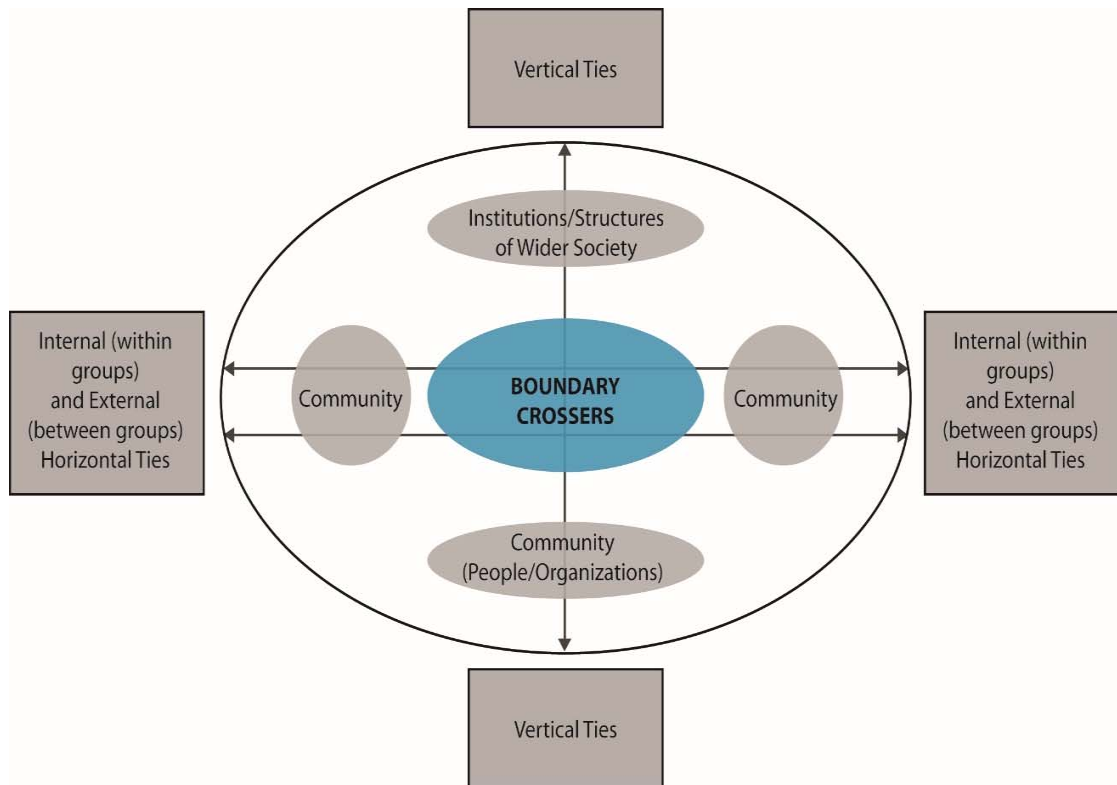


Figure 23: Communities of place

The links described by Kilpatrick et al. (2009) can thus be applied to the analysis of Andean CHWs as potential boundary crossers, or individuals who use both horizontal and vertical ties to cross the social boundaries of exclusion in order to link community members with the formal health services, as will be discussed throughout the remainder of this chapter.

In contrast to communities of place, a “community of practice” as introduced by Wenger (n.d., para. 2) refers to a relatively new concept popular in social learning theory which is defined in the following passage:

Communities of practice are formed by people who engage in a process of collective learning in a shared domain of human endeavor: a tribe learning to survive, a band of artists seeking new forms of expression, a group of engineers

working on similar problems, a clique of pupils defining their identity in the school, a network of surgeons exploring novel techniques, a gathering of first-time managers helping each other cope.

This concept has thus also been applied to this study because it provides a useful means to analyze how boundaries may be defined in terms of shared social practices based on shared experiences (e.g., shared ethnic experiences) as will be discussed subsequently. Wenger further notes that there are three characteristics crucial to communities of practice: the *domain*, the *community*, and the *practice*. The “domain” is defined by the shared domain of interest between the members of a specific community of practice. This can be, for example, a shared interest in overcoming social boundaries, such as Andean community members having to cope with exclusion from health services. The “community” refers to a group of people engaging in joint activities and shared information, such as a group of health professionals interacting with each other to learn the preferred ways to deliver maternal health services in the communities. Finally, the “practice” refers to members of a community who develop a shared cache of resources through time and interaction. This can be, for instance, a group of people with a shared set of stories or life experiences based on their interaction with each other over time. Community members meeting together casually to discuss their respective experiences in the health centers can thus potentially serve as an example of shared practices (See Figure 24 for a visual representation of communities of practice).

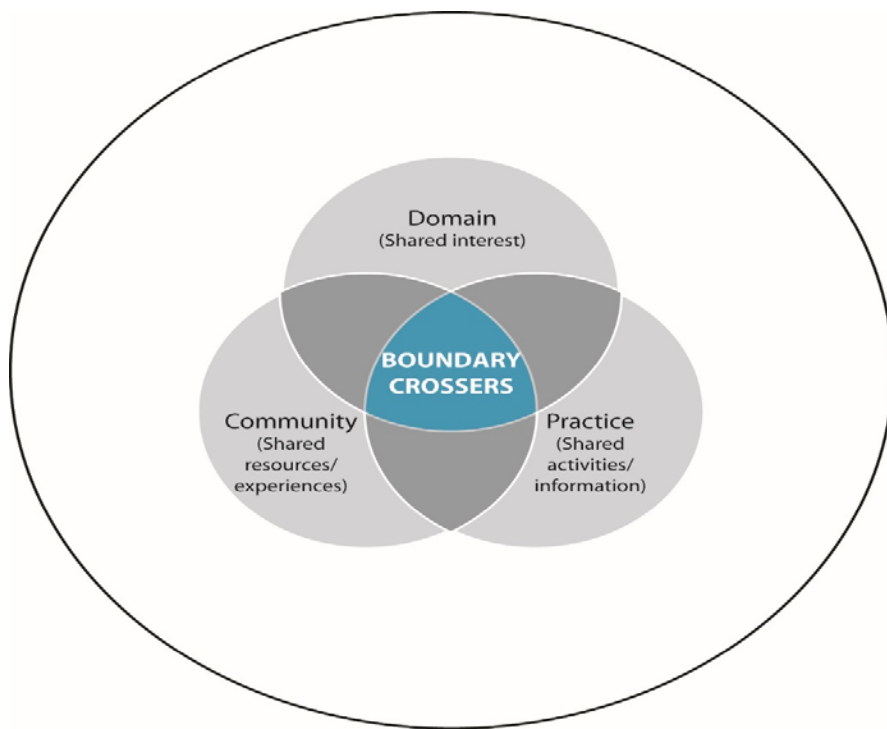


Figure 24: Communities of practice

It is important to note, however, the role of intentionality in identifying communities of practice. Members of a community who interact with each other in a way that results in a process of collective learning does not always have to be intentional, it can also happen as a result of incidental interactions with members of the same community given the presence of the three characteristics described above (Wenger n.d.). Communities of practice as defined in this study are therefore characterized by the varying shared societal practices – based on shared experiences – particular to each of the social groups in this study. This can, for example, refer to Andean community members collectively deciding how to improve access to maternal health services, or CHWs collectively choosing which model of health care to deliver to their patients. These societal practices are each comprised of a system of beliefs, functions and expectations based on each group’s shared traditions, values and norms. This study thus utilizes Kilpatrick et al.’s (2009) concept of communities of place with Wenger’s (n.d.) concept of communities of practice in a combined manner to analyze how the collective belief systems of a group of

people linked by horizontal or vertical ties may be influenced by each group's shared domain, community and practice (See Figure 25 for a visual representation of how communities of place and practice intersect). This can, therefore, also refer to Andean community members who rely on traditional medicines and practices to ensure their wellbeing, or equally, to health professionals who rely on biomedical models of care to heal their patients. Thus, while a community of place is bounded geographically or spatially, a community of practice as utilized in this study is bounded by the beliefs, functions and expectations of a particular social group engaging in a particular social activity.

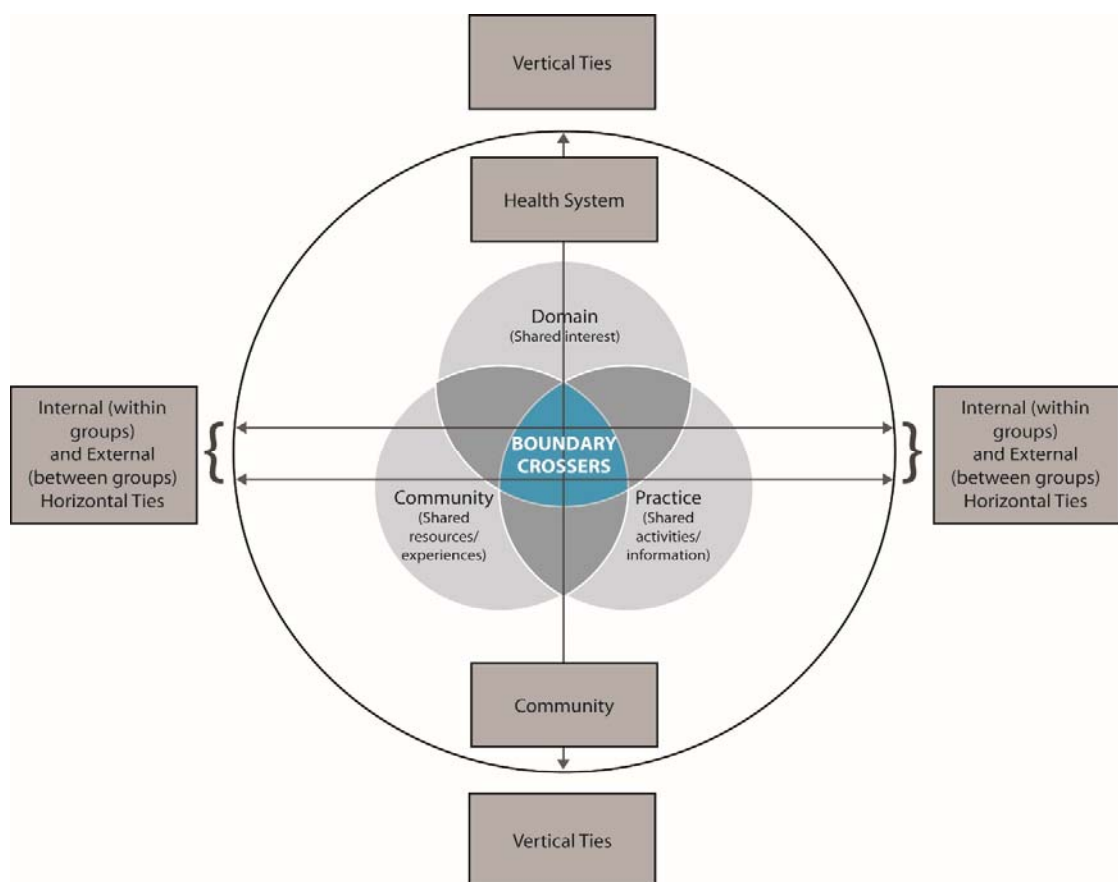


Figure 25: Intersection of communities of place and practice

The juxtaposition of traditional and biomedical models of care present in the study area provides a useful starting point to discuss communities of place and practice, and how

CHWs might be enabled (or enable others) to maneuver between these bounded spheres. Despite global awareness that the social determinants of health account for at least 90% of health outcomes worldwide (World Health Organization 1997), the links between community influences and individual health in LMICs are often ignored (Minkler 2005). Also often ignored is the potential role certain community level actors, such as CHWs, might have in influencing individual health behaviors or the way health services are carried out (Kilpatrick et al. 2009). The reasons for such a limited understanding of community or CHW influences on individual health can potentially be attributed to tensions between the biomedical model of health, with its focus on the individual, and alternative models of health (such as traditional Andean healing practices), which place more emphasis on community influences to human behavior, and therefore health outcomes, as explained in Chapter 5, Section 5.4.2. For instance, education for health professionals following a biomedical model mainly focuses on individual behaviors as the solution to health problems (Campbell and Jovchelovitch 2000). Accordingly, Kilpatrick's et al. (2009, p.284) study about the role of rural health professionals, suggest that the focus on the individual is likely due to the perception that "...[biomedical] health professionals do not feel they have any influence on social determinants of health, and that influencing social/community determinants is outside their professional scope". Similar to Kilpatrick et al.'s (2009) study, the findings from this study suggest that individuals working in a health promotion or public health capacity (e.g., NGO staff members) are an exception to this view and place great emphasis on their responsibility to address social or community determinants of health. Staff members from both of the NGOs that participated in this study, for instance, pronounced several times during informal conversations that they felt it was up to them to try to enforce change, rather than the doctors. When prompted to elaborate on this view, one staff member (NGO worker 2) specifically mentioned that if it were not for the NGOs work in promoting community accountability through appointing CHWs to act as a health authority within their communities, the community members would have even less awareness of their rights to receive quality health services.

The CHWs taking part in this study were thereby found to work across the perceived boundaries of two different approaches to health care – traditional and biomedical – incorporating aspects of both models into their delivery of care. In this way, through a process of boundary crossing, CHWs are enabled to move somewhat freely between geographic communities of place (i.e., between the community and health facilities), and communities of practice (i.e., evidenced by the integration of traditional practices with biomedical practices). CHWs, thus, operate within both the communities and the health system (i.e., communities of place). In so doing, they interact with their fellow community members who likely share the same preferences and experiences in regards to Andean healing practices (e.g., shared Andean health beliefs and practices), as well as with health professionals who likely share the same preferences and experiences with the biomedical model, such as professionals working within Peru’s formal health system (i.e., communities of practice). This is important because if CHWs are in a position to move between communities of place and practice, they may thus be enabled to address the social and community determinants of health characterized by the social boundaries of exclusion.

Evidence collected from the CHW group demonstrates the types of maternal health services that are typically conducted by CHWs, and how these varying activities might enable CHWs to physically maneuver between their local communities and the health facility (communities of place), as well as to incorporate alternate models of health services into their care roles (communities of practice) as inferred by the following passage:

“...for the pregnant women, the responsibilities of community health workers are to ask if they are attending their prenatal checkups, if they are going to the health center to have their checkup, to check how they are doing, to see if there are alarm signals or even if they are maybe not feeling well. We have to look in on them every month, also we go to the health center to ask if the pregnant women are attending their checkups or not, and if they are not going, then to go back [to the community] and tell the women that they have to go [to the health center], that it is very important for them, for their babies...we also go to the health centers to learn how to help them. We give talks in the communities, we tell the women that they need to eat well...and for breastfeeding women it is the

same as the pregnant women. We ask if they are taking the baby to the health center, we tell them they have to take the baby [to the health center] for checkups. And also that they have to make sure their baby has access to his own food, because he depends on that, just as much as the breast milk. Also, some doctors tell us that that they should be using the colostrum but we know they don't do this and we tell them [the women], that's it's okay to give the babies tea while they discard the spoiled milk,⁷⁶ this is okay as long as they continue to eat healthy so that their unspoiled breast milk is healthy." (Community Health Worker 2)

Analyzing the movements of CHWs, however, has highlighted some of the tensions which may arise when trying to maneuver between pluralistic approaches to care. CHWs, for example, might be enabled to cross between boundaries of practice (i.e., between the traditional model and the biomedical model) by incorporating traditional Andean beliefs into biomedical practices. For example, the CHW, having firsthand knowledge of both models of healthcare, through personal exposure to both, can use horizontal ties based on experience to decide appropriate ways to integrate the two models. Yet, in doing so, they may also run the risk of promoting particular health behaviors which are considered physically harmful according to the dominant biomedical view. For instance, despite indicating awareness that the health professionals prefer that women feed their infants the colostrum (i.e., biomedical preference), one CHW stated that it was okay to feed the infant tea rather than the first milk (i.e., traditional preference). This advice was given in consideration of traditional Andean beliefs, which assume that the first milk is spoiled and should thus be discarded. The CHW therefore condoned giving the infant tea despite the potential dangers this might have from a biomedical perspective. From this, it can be inferred that although this CHW is providing a way for pregnant women to follow a traditional model of care by attempting to integrate this into the biomedical model (i.e., by promoting eating nutritiously to ensure healthy breast milk), the practices involved may not necessarily be the safest option. As such, although the CHW may be enabled to act as a boundary

⁷⁶ A traditional Quechua belief is that women are more at risk of becoming sick from evil spirits during pregnancy. The colostrum is believed to be spoiled because it was contained in the woman's body throughout pregnancy. The general practice is to discard the colostrum. The infant is generally fed herbal tea while the spoiled milk is being expelled (Evans and Myers 1994).

crosser by moving between the two boundaries of practice, the end result may not always be in the best interest of the recipient of care despite the intentions. This again raises questions over which belief system should be granted more authority (as highlighted in Chapter 2, Section 2.4), and consequently who should be held accountable for ensuring the safety of the care methods provided. If CHWs are thus entrusted to act as opinion leaders and as a result become enabled to cross boundaries, it would be equally important to ensure that the practices they condone are indeed safe for all parties.

The above example was presented to examine the role of boundary crossing in bringing together different models of health care, and the benefits or problems that may arise from this. This concept is expanded to identify additional ways in which CHWs might be enabled to act as boundary crossers, thus potentially facilitating interaction between the different actors traditionally bounded by communities of place and communities of practice. The following subsections discuss the third and fourth theoretical categories which have been developed to explain how CHWs might be able to cross additional boundaries of place and practice, such as those resulting from intergroup tensions in order to help overcome the social boundaries of exclusion, as introduced in the previous chapter.

6.5.1 Theoretical Category 3: Adopting a Professionalized Identity

The third theoretical category describes how adopting a professionalized identity might facilitate boundary crossing and social mobility for indigenous Andeans who become CHWs. A professionalized identity occurs when one gains a professional status, or as Fuller (1995, p.467) more specifically explains:

Professionals are described as possessing a discrete body of knowledge acquired through special training. Members of a profession claim the right to exercise autonomous decision making about their work...Professionals are likely to come from the dominant social group and from families whose members are also professionals...Most of the professional workforce remains distant from the life of non-dominant groups, such as non-English speaking background immigrants, who are marginal because of their different cultural and social backgrounds.

This definition is important because it highlights how professionalization more commonly occurs within a dominant social group. This is consistent with observations made in this study, in particular in the relationships between the largely non-indigenous medical professionals and the indigenous users of medical services. Accordingly, participants in this study raised concerns about the poor interpersonal relations existing between indigenous community members seeking health services and non-indigenous health professionals providing care. Despite efforts to integrate culturally acceptable care into the western biomedical system as described in Chapter 3, Section 3.6.3, there are still major barriers to accessing acceptable maternal health services which are exacerbated by the social boundaries of exclusion. An interesting finding however, was that indigenous community members who also identified as CHWs seemed better equipped to negotiate their way across the social boundaries of exclusion because they had more opportunities to interact with different social groups. The process of adopting the professionalized identity of a CHW was thus analyzed in order to examine how it might contribute to improving the interpersonal relations of health users and providers, or at least between CHWs and the community members and health professionals they interact with.

As explained by Laurie et al. (2003), for example, there is a common notion in the Andes that gaining employment or becoming a professional in a field more commonly associated with the non-indigenous population (i.e., the socially dominant group) is one of the only ways that ethnic discrimination can be avoided. This has often been attributed to the “whitening affect” of achieving professional status (de la Cadena 1998; Jenkins 2008; Laurie et al. 2003). Similarly, Jenkins (2008, p.143) explains that “within hierarchical societies such as Peru, the formal status and title of a professional occupation are particularly valued.” Learning how to cope with discrimination through gaining the formal status of CHW was likewise observed in this study. CHWs, for instance, reported feeling better able to act as a community spokesperson (i.e., opinion leader) when cases of discrimination against other community members were observed in health care settings. One possible reason given for this might be that CHWs

sometimes felt increased feelings of respect from other community members leading them to feel a greater sense of authority as indicated in the following quote:

“The campesinos respect my opinion as a CHW. Others in the village also see me as more educated. When I wear my uniform I feel that they respect me more. I want to make my family’s life better also. I don’t feel as marginalized when I am in my uniform...I have more of a sense of authority. I’m proud of being a Quechua but I also want to get ahead. Sometimes being a campesino doesn’t let me do this. Being a CHW helps me in this way.” (Community Health Worker 1)

One theme which can be drawn from this is that boosted feelings of confidence, resulting from having a professional status may possibly lead to decreased feelings of marginalization. The CHWs in the study, for example, often referred to feeling less marginalized while in uniform, thereby feeling a greater sense of authority. The uniform in this case would be symbolic of the socially dominant group. Feelings of authority resulting from being symbolically associated to the dominant social group may thus be an important factor in improving one’s social status, or at least having the confidence that overcoming marginalization or discrimination is more likely. Another theme that can be identified is the returning presence of internal conflict as described by the first theoretical category in Section 6.4.1. Feelings of pride in having Andean heritage may be present, but this is also noted to be a limitation to achieving greater rights or status in Peruvian society. Some may thus consider that becoming a CHW may thereby allow an individual to emphasize his or her professionalized identity over ethnic identity as a way to overcome this limitation. However, the notion that taking on the dominant professional culture is necessary to overcome the limitations of being indigenous implies the implicit acceptance of indigenous “inferiority”, thus perpetuating inequality.

Additionally, some participants expressed concern that even though being a CHW helped them gain more authority within their communities, thereby strengthening horizontal ties, this wasn’t always the case when interacting with health professionals. Tensions were evident between different cadres of health professionals, and many health professionals did not consider CHWs to be formal members of the health system:

“The CHWs, they are just there for referrals. They are not professionals because they have limited tasks and limited education. They only have limited medical knowledge. They only know what we teach them during the trainings. Half the time they forget these things though. I do always try to locate the CHW when I go to the communities. If I can’t find my pregnant patients, then I have to give the message to the CHW to make sure they find the girls and make them go to their checkups.” (Medical Doctor 3)

While some health professionals felt that the CHWs were merely community members with an extended role and thus not part of the formal health system, they acknowledged that CHWs were useful for relaying information. Consequently, even though some medical doctors may not feel confident in the medical knowledge of the CHW, the CHWs themselves view their role as important for creating links between the health users and the health professionals, thus also potentially facilitating vertical ties as indicated in the following quote:

“When I am in my community, I am respected. But this is not the same when I go to the village for the trainings, or when the doctors come up here. It’s like they think I am just someone they can order around. I am the first person my neighbors go to when they are sick, but when I am around the doctors, they ignore what I say. It’s like they don’t believe I know what I am talking about. I deal with this though, because at least I know I am helping my community, even if the doctors don’t take us seriously.” (Community Health Worker 5)

Tensions between CHWs and community members did sometimes arise when trying to determine who is considered professional and why. One community member, for instance, explained during an informal conversation that although he believed the CHWs in his community did the best they could to help the other community members, they were still not as experienced as the doctors (Community member 4).

Debates about CHWs working in LMICs, in particular in rural areas, highlight the lack of consensus over whether rural CHWs can be considered to hold professional status (Fuller 1995; Kilpatrick et al. 2009). One potential explanation for this from the community perspective could be in the way CHWs perceive their own professional identities, and want to be perceived by others. A study by Jenkins (2008), for example, which examines professionalism among grassroots women health promotion activists in

low-income settlements of the outskirts of Lima, explains how health promoters have to maintain a delicate “balancing act” between being considered experts while also still being considered part of the community. Jenkins (2008, p.150) describes how some of the health promoters in her study exhibited an “...ambivalent attitude towards constructing themselves as professionals” which was likely due to being from the community itself (one of the main requisites of being a health promoter or CHW), rather than being an outsider. As she explains:

A particular tension was evident throughout the health promoters’ discussions, between perceiving themselves and wanting to be perceived by others as ‘experts’, but simultaneously wanting to be seen as part of the community – something with which being an expert was seen to be incompatible. (Jenkins 2008, p.150)

Thus, while being from the community itself has been identified as important for strengthening horizontal ties within communities, findings from this study indicate that some CHWs may also be reluctant to perceive themselves as professional when interacting with other community members. One CHW, for example described how she did not tell her neighbors that she was also training to be a nurse, rather she preferred to only be identified as a CHW while in her community:

“They do not know I am studying...those who do know treat me like a professional...but as a CHW, I am the same as them, with the same customs and language. They want someone that understands them, that can explain things to them...if I am a nurse, they say I might forget these customs when I move to the city...so I’m happy to wear my CHW jacket instead of my nursing uniform when I visit my neighbors.” (Community Health Worker 2)

Similar to the quote provided on page 242 by Community Health Worker 1, this quote highlights the importance of uniform in constructions of professionalization. However, while Community Health Worker 1 discusses feeling more respected and less marginalized while wearing a uniform, Community Health Worker 2 infers that this may only occur with the CHW uniform, rather than a uniform associated with higher cadres of medical professionals. The uniform in this case shows how constructions of professionalism can be embodied while simultaneously creating tension between CHWs

and other medical professionals. This is again consistent with Jenkin's (2008, p.151) study of health promoters in Lima. As she explains, "...[the health promoters'] attitudes to uniforms and appearance serve to demonstrate this tension between wanting to be acknowledged as experts but identifying as women from [the settlement]".

A possible reason that this tension occurs is that having expert knowledge associated with the socially dominant group may simultaneously create a barrier between the CHWs and other community members. Thus, despite the potential for CHWs to move between bounded spheres, such as between the community and health system, moving into a new professionalized space could also result in creating additional boundaries, such as alienating oneself from the original community member group. Consequently, tensions between indigenous health seekers and non-indigenous health professionals that contribute to the social boundaries of exclusion may potentially be overcome by becoming a CHW. For example, it was observed in the data that by interacting with members of the dominant social group, CHWs may have a greater opportunity than their fellow community members, who did not hold a traditionally non-indigenous professional status, to overcome the social boundaries of exclusion:

"When they asked me to be a CHW, I was happy...because this meant that I would learn from the doctors how to help my community. This is important information and we don't always have access to this knowledge up here [in the community]. When I go down [to the village] for the training workshops...I can see and learn ways to improve my life...maybe they [non-indigenous] still treat us badly for having different customs...but maybe as a CHW they will see me as more educated and this might change." (Community Health Worker 1)

This quote is consistent with data gathered during informal conversations with community members. One community member, for instance, described how he felt it was better to be a CHW because he felt they had more opportunities to interact with other health professionals. He explained that more interaction, in turn, allows the CHWs to explain some of his community customs to the health professionals which he hoped would discourage discrimination or disrespectful treatment of the indigenous population (Community Member 4).

The examples from the data provided in this section thus far have explained some of the ways in which the participants construct notions of professionalization. For instance, factors such as education and appearance as described above seem to play an integral role in determining whether or not CHWs are perceived as “professional”. As explained in Section 5.2.2 of the previous chapter, CHWs are voluntary, appointed by their own communities and have a working knowledge of the Spanish language. Though formal education is not a requirement of being a CHW, they are expected to attend the training workshops hosted by the health professionals, municipal governments and NGOs, and thus have a degree of “expert knowledge”, that is, the minimum knowledge required to be a CHW (e.g., Spanish language, basic first aid). Accordingly, having expert knowledge may be closely linked to the common notion in the Andes that gaining employment – and thus gaining a professional identity – is seen as a useful mechanism for avoiding discrimination (as described in the beginning of this section). However, while professionalism may be viewed as a means for social mobility, it is also sometimes viewed negatively. Another article by Jenkins (2009), for instance, explains that while the health promoters in her study may have been considered “experts”, they were also situated within broader hierarchies of knowledge that may constrain their professional identity:

The term ‘professional’ has quite contradictory connotations in Peru, where it is viewed with both suspicion and deference. A widespread suspicion toward medical professionals particularly stems from the poor quality of medical care that many people—especially the poor—have received, and to a large extent continue to receive, from underfunded government health services. (Jenkins 2009)

Jenkins (2009) goes on to explain that despite these negative views, having a professional identity continues to be highly respected and valued in Peru. This is consistent with findings from this study as exhibited in the data included in this section, particularly in terms of the value placed on education and outward appearance. Thus in a society where, as Jenkins describes, (Jenkins 2009, p.885), “‘shades of whiteness’ [underly] a class system in which middle and upper classes are perceived to be ‘whiter’ than lower class individuals”, it seems relevant that gaining expert knowledge, or

education more broadly, can be a means to associate with the dominant social class in order to avoid ethnic discrimination.

Though the debate remains as to whether CHWs were considered members of the health system or not, the data suggests that they were capable in facilitating both horizontal and vertical ties because of this informal (albeit contested) professional status. In turn, the act of becoming a CHW and therefore adopting this professionalized identity can likely increase the opportunity for indigenous community members to feel less marginalized, thereby also acting as a useful mechanism for increasing their own social mobility.⁷⁷ As has been described, adopting the professionalized identity of CHW, however, also potentially risks creating yet another boundary between CHWs and the original community group. Some ways in which this might be avoided are discussed in the following subsection.

6.5.2 Theoretical Category 4: Bargaining Ethnic Identity

The fourth theoretical category – central to the development of the substantive grounded theory – that was developed during the analysis was “bargaining ethnic identity”. The theory of ethnic bargaining, as explained by Jenne (2007), claims that minorities who experience or expect an increase in their bargaining power will tend to radicalize their political demands. Bargaining theory in general is a branch of game theory which rests on rational choice assumptions where “...rational agents in a suitably idealized bargaining situation will agree on a specific, unique distribution of the benefits of cooperation...” (Verbeek and Morris 2010, para. 15). Bargaining models, as such, are based on the power of a group to bargain for a solution in which the outcome for the invested group is improved (Verbeek and Morris 2010). For example, Jenne’s (2007) theory of ethnic bargaining applies a rationalist theory of bargaining to examine the politicization of ethnic identities in the case of post-communist countries of East Central Europe. Under this view, minority ethnic groups in her region of study began to use a language of self-determination and rights based empowerment originally adopted by the

⁷⁷ This will be discussed further in Sections 6.6.1 and 6.6.3.

great powers during the First World War to redraw political boundaries, in order to have a stronger political voice. Jenne's view is thus based on the notion that individuals within ethnic minority groups are considered rational agents capable of challenging ethnic cleavages through consciously bargaining their political power. Politicizing ethnic identities in this manner grants agency to ethnicity and the ways minority ethnic groups categorize themselves depending on the perceived expectations or consequences from either their own in-group or other out-groups. The grounded theory discussed in this chapter has hence been constructed on the basis of these notions of ethnic agency. Building on the examples given in the previous chapter and drawing on the concept of ethnic bargaining, this section further examines how the ethnic identities of indigenous Andeans in the study area, particularly CHWs, can sometimes be used pragmatically as a means to cross the social boundaries of exclusion. In this regard, the experiences of CHWs provide a valuable example of how particular social identity groups might be enabled to cross these boundaries.

Data collected from the CHW group, for example, explains how some participants coped with perceived experiences of disrespectful treatment while attending a CHW training workshop by strategically de-emphasizing their ties to indigenous identity. This was done by speaking Spanish rather than Quechua or by hiding indigenous customs when visiting urban areas as the following two quotes from a CHW suggest:

"...There was nobody there when we [CHWs from the same community] arrived at the training location. We left very early this morning and the walk was long,⁷⁸ but we still had to wait...it's because they don't respect us. If we are late they yell at us, but if they are late...it's like nothing. This is discrimination. I like being a CHW but if they are going to treat us like we are not important, then what is the point? The only way I can make sure my family doesn't have to go through this is if I teach my children to speak Spanish and to hide our customs."
(Community Health Worker 4)

"I am proud of my customs, I am proud of my ancestors. But if I want to make money or get treated with respect when I go down to the towns, then I have to

⁷⁸ The CHW reported that it took five hours to walk from the community to the location of the training site.

hide these customs. I became a CHW because I wanted to help my community...but also this was to make sure I would have opportunity to make money or to have a better life.” (Community Health Worker 4)

The CHWs explained that de-emphasizing one's indigenous identity was sometimes the only way to avoid discrimination and increase the potential for financial and social opportunities for Andean community members. Examples such as these exemplify further societal tensions which exist over social mobility in the region. In the past, theoretical arguments such as those explained in Jenne's (2007) work, which connect democratic bargaining to ethnic social movements, were traditionally based on primordialist or instrumentalist assumptions (such as those described in Section 6.4.1) where ethnic groups were viewed as homogenous (Chandra 2004; 2006). The boundaries of such groups were considered fixed and their demands were often perceived as threatening to the out-group, or other ethnic groups such as occurred in Peru during the political conflict of the 1980s and 1990s (McClintock 1992). Explaining ethnogenesis, or the origins of acquiring an ethnic group identity, through primordialist or instrumentalist views assumes that forms of ethnic mobilization, such as pro-indigenous development projects, or primary health care expansion to rural communities, could be the result of a shared “collective ethos”, where a strong sense of ethnic or racial identity might emerge from the pursuit of indigenous homogeny (Chandra 2001). Instrumentalists, such as rational-choice theorists as described above, for example, may place greater emphasis on indigenous groups utilizing their ethnic identity as a means of utility maximization rather than purely on ethnic solidarity, as would be the case for primordialist theorists.

The grounded theory developed from the data questions primordialist assumptions of fixed group homogeneity and instead combines the instrumentalist approach where ethnicity is granted agency, with constructivist notions of fluid ethnic identities. Constructivist approaches to theorizing ethnic identity traditionally assume that any sort of shared symbolic framework for categorizing ethnicity is often artificially imposed upon by both the in-group as well as varying out-groups (Chandra 2001). Through the constructivist view, group homogeneity is based on fluid ethnic categories which are

constructed and change over time (Chandra 2001; 2006). The speed and manner in which these ethnic categories are constructed over time can be dependent on the historical or institutional context as it changes (Chandra 2001). This argument implies that ethnic group categories may be unstable for short or long periods of time while they are constructed and reconstructed (Chandra 2001). The implications of this instability are explained by Nelson Kasfir, a political scientist:

Identifying someone as a member of an ethnic category at a particular time and in a particular place does not mean that, for political purposes, he will continue to hold that identity in other times and at other places and other times...if categories are fluid, identity may shift dramatically not only from one ethnic category to another, but from ethnicity to class to religion. (Kasfir 1979, p.373)

The view that ethnic groups are fluid now forms part of the general consensus among Latin American scholars (Canepa 2008; Garcia 2005; Paredes 2007; Ramirez-Valles 1998). One of the challenges of applying this consensus to this study however, is that using the concept of ethnic identity as a unit of analysis becomes more difficult due to its fluidity and changing nature. Despite this challenge, this study explains how CHWs, by being situated on the peripheries of the social boundaries of exclusion may be enabled to use their professionalized status as a tool for ethnic bargaining (Figure 26).

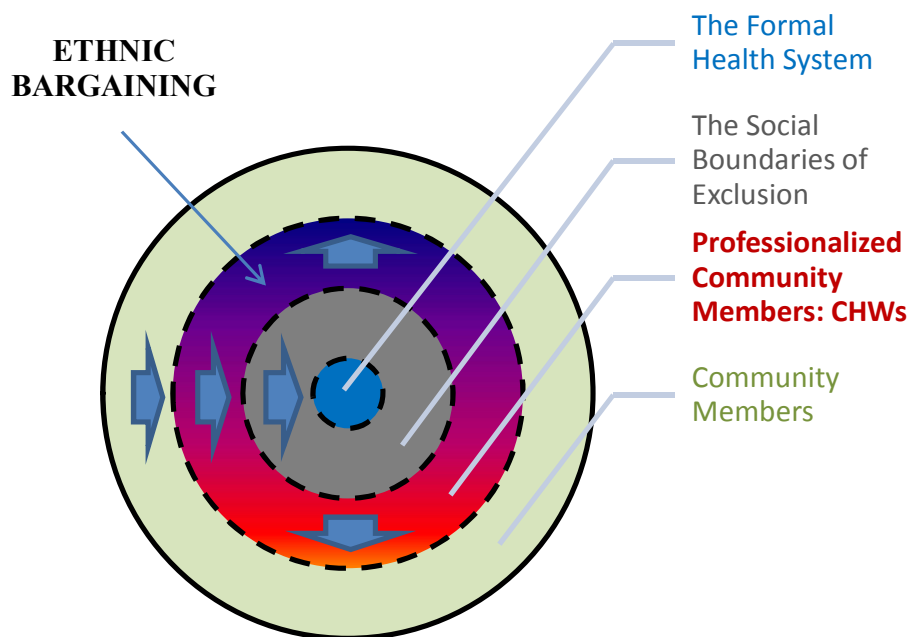


Figure 26: Crossing the social boundaries of exclusion through the ethnic bargaining of professionalized community members (CHWs).

Using professionalization to bargain ethnic identity thus corresponds to Kasfir's (1979) view that identity can be shifted dramatically from different social statuses. In the case of this study, social mobility was identified as a positive outcome of ethnic bargaining, in particular for enhancing the relationships between indigenous women and their families in need of maternal health services and their potential non-indigenous health providers, as will be discussed in the following section.

6.6 Utilizing Bargained Identity to Enhance Maternal Health Service Relationships

The theoretical categories explained above were all identified as important factors for enhancing the social mobility of indigenous Andean community members (namely CHWs), thereby facilitating access to maternal health services. Accordingly, one way indigenous Andean community members seemed to deal with barriers to care resulting from interethnic tensions was by using bargained identities during health care interactions. As described in the previous subsection as well as Chapter 5, participants

would sometimes take active measures to minimize any associations with their indigenous Andean identity. For example, as has been described, participants in this study frequently discussed the importance of making sure their clothes and skin were visibly clean while visiting the health centers.⁷⁹ This was done to appear more like individuals who did not work in the fields, and therefore would be more likely to have a clean appearance. Another important indicator of indigenous identity was indigenous dress. One CHW for instance discussed how he valued his indigenous identity and felt pride in his indigenous clothing, but at the same time, also felt the need to consciously hide these identifying markers while interacting with health professionals:

“Well, in this case, me, more than anything, I feel happy that I am a Quechua speaker. Because of Quechua, I feel proud. And I...identify as this. But I also identify myself in terms of how people are treated. How they treat me. When I support [the community]...the people appreciate me a lot...what I help with most in the community is with the poor people. The ones who wear the pollera [indigenous dress]. That is how I identify myself...We mustn’t lose our customs...we should value them more and more. So that is how I most often identify myself. With the chullo [indigenous hat] and poncho and that. This is also why I do not like to go to the health center. Because I have to hide this identity when I am with the doctors. This is just easier than being treated badly for my poor clothes.” (Community Health Worker 1)

Feeling the need to hide one’s indigenous identity while interacting with health professionals could be reflective of the internal conflict explained in Section 6.4.1. Further, it could also reflect the strategic bargaining of ethnic identity (i.e., placing less emphasis on indigenous markers such as clothing) as a way to avoid poor treatment from the doctors and their discrimination of indigenous people. In a setting where it is common for there to be poor intergroup relations between indigenous community members and non-indigenous health professionals and coordinators of health care (such as municipal government and NGO workers), many indigenous women and their families choose to avoid health care interactions. In this regard, CHWs can encourage

⁷⁹ Due to the nature of subsistence agriculture and having to walk long distances through dirty or muddy terrain, it was often difficult to maintain a visibly clean appearance.

women to go to health centers or to be available for their check-ups when the doctors conduct community visits. CHWs might therefore be able to act as a liaison between indigenous community members and health professionals. The ways that CHWs can influence health seeking behavior (and to a lesser extent provider behavior), were found to depend on a number of cognitive processes, such as being empowered to influence health seeking behavior, negotiating whether to trust the authoritative knowledge of health professionals, and deciding how to navigate interactions between health service seekers, providers and coordinators of care. These cognitive processes were thus analyzed and developed into the final three theoretical categories: 5. *Being empowered*, 6. *Negotiating trust*, and 7. *Facilitating interactions*. The following subsections explain each of these theoretical categories in turn and further detail how ethnic bargaining may be used by CHWs to act as boundary crossers, thus facilitating interactions between health seekers and providers, in order to enhance maternal health service relationships. Figure 27 provides a visual representation of all seven theoretical categories and how they intersect in a way that highlights ethnic bargaining as central for enhancing maternal health service relationships.



Figure 27: Enhancing maternal health service relationships through ethnic bargaining

6.6.1 Theoretical Category 5: Being Empowered

The fifth theoretical category examines power relationships between the groups in this study and explains how the disempowerment of socially excluded groups such as indigenous Andeans perpetuates discrimination and marginalization against them. Power, in general is an important sociological concept which can have many different meanings. One of the most common definitions is that of Max Weber, who defined power as the “ability to control others, events, or resources; to make happen what one wants to happen in spite of obstacles, resistance or opposition” (Crossman 2015, para.

1). A contrasting definition famously used by Karl Marx views power as related to social classes and systems, rather than individuals. Marx argued that those who held power were those who belonged to the social class with greater access to production. Subordination of social classes was thus based on economic access (Crossman 2015). Yet another definition was given by Talcott Parsons who defined power as a result of "...a social system's potential to coordinate human activity and resources in order to accomplish goals" (Crossman 2015, para. 3).

Thus, linked to the concept of power, "empowerment", as defined in sociological terms, is the political process of "...gaining control over self, ideology, material and knowledge resources which determine power" (Sociology Guide 2015a). More specifically, as Rowlands (1997, p.15) states, "individuals are empowered when they are able to maximize the opportunities available to them without constraints". The state of having power, or being empowered was identified both by the participants and researcher as key to raising one's social status in Andean communities and thus gain greater social mobility, as one participant explains:

"We in the community have to be more confident...we have to encourage others to treat us better, otherwise they will continue to step on us. If I am confident in the rights that I have, then I have power to hopefully change my life...change for more opportunity." (Community Health Worker 2)

The fifth theoretical category was therefore labeled as such to reflect the importance of empowerment for navigating into different social statuses. As power and knowledge are known to be inevitably linked (Gaventa and Cornwall 2011), indigenous Andean community members have been historically disempowered due to a lack of opportunities for education. This was particularly the case in the study area given Cusco's history of colonial domination. One NGO worker, for example, stated that indigenous community members exhibited a "culture of submission" due to this history. The NGO worker explained how the historical experience of domination has led to what many of the participants themselves also referred to as a "culture of submission". This refers to the notion that because indigenous Quechua speaking Peruvians living in Cusco have been

accustomed to taking orders and being in a lower social class for centuries, then they often do not know that they have rights and resultantly accept their status as “second-class citizen” as just the status quo. The historical lack of empowerment among indigenous Andeans conflicts with the feelings of pride, and consequently empowerment that many community members expressed over their indigenous heritage. Other participants, mainly NGO workers, also emphasized promoting indigenous pride. For example, the NGO workers spoken to strove to identify the ways in which community members’ cultural traits or behaviors could serve to encourage adherence to medical advice. The development projects coordinated by the NGOs working in the communities generally aimed to empower community members to feel pride in their cultural heritage and take responsibility over their own health needs by asserting their rights.

Accordingly, the topic of indigenous rights was consistently discussed amongst the NGO participants. In this regard, the NGO workers described how community members in Cusco’s indigenous Andean communities were viewed to relegate themselves to this culture of submission given their history of domination. Corresponding to Fanon’s (1964) conceptualization of alienation as defined in Section 6.3, the notion that community members have a historical tendency to accept inequalities as an expected part of daily life was thus expressed frequently and often discussed in the context of promoting indigenous rights and empowerment. This is illustrated in the following quote:

“We shouldn’t just be telling them [indigenous Andeans] what to do and how to do it. We should be respectful of their beliefs. But they are so used to being told what to do. Many don’t even know that they have a voice. That they CAN speak for themselves. That they have rights! So we work with them and encourage them to be proud of their heritage, of their culture...to use this pride to empower them to make their own lives better...so that they don’t just sit there and take it” (NGO Worker 3)

Many of the projects run by NGOs were hence oriented towards encouraging indigenous Andeans to take ownership of their health needs as illustrated in the following quote:

“Our projects focus on promoting awareness and educating the community members so that they can know how to take care of their health...to recognize

that they should see the doctor when they need to. Sometimes they have too many children and they are embarrassed to tell people [when they become pregnant] ...So we go in and we talk what about why they might be embarrassed and how they think they should handle these situations...Their husbands might get angry, their neighbors might whisper about them....So what should they do? I like to involve them...I ask them what they think...to role play...so we try to incorporate their beliefs and customs into the things we talk about...this way it makes sense to them...and they have a say in their own health.” (NGO Worker 1)

One method of empowering community members to observe their health and consider their rights was through raising awareness of ways to improve community health through promotion and education. Specific methods to involve the community members included promoting collaborative problem solving strategies to empower community members to be aware of their health and seek care if they need to regardless of the potential cultural stigma associated with their varying health needs (e.g., frequent pregnancies). Empowering community members to feel pride in themselves was interpreted to be a necessary prerequisite for asserting the right to health care and therefore improving community livelihoods. In contrast to many of the government employees who focused on *directing* the activities of community members, the NGOs primarily stressed the importance of *collaborating* with community members and working with them to develop initiatives which are respectful of their attitudes and beliefs.

Being empowered to take ownership of health is therefore perceived as an important aspect of improving access to health services. In this regard, as CHWs are ideally situated to act as boundary crossers, empowering CHWs may also have a number of positive implications for improving the health of other community members. Drawing on the definition offered by Talcott Parsons (1967) above, “power” is an important “...mechanism which can bring about changes in the action of other units, individual or collective, in the processes of social interaction” (Lukes 2005 [1974], p.31). Parson’s view of power thus depends on the “institutionalization of authority” (Parsons 1967, p.331). A community member who takes on the professionalized status of CHW, through increased contact with institutions such as the health system, thus also becomes

an authority figure to those out with the institution (e.g., community members who are not CHWs). The general increase in authoritative knowledge a CHW can gain from this new professionalized status suggests that boosted levels of confidence may thus contribute to CHWs feeling respected by other community members. This form of empowerment resultantly corresponds to the potential for CHWs to have increased confidence in terms of believing they can act as opinion leaders to positively influence other community members' health seeking behaviors as well as the behavior of health providers. As such, acting as a liaison between the two can potentially bring about changes in the ways different social identity groups (e.g., indigenous community members and non-indigenous health providers) interact with each other. This has been shown to be important at the community level, but given the CHWs did not show evidence of challenging weaknesses in the health system, it would be less likely for feelings of empowerment to have any influence outside the boundaries of the community. The factors which may lead CHWs to feel empowered however were interpreted to occur as a process of trust negotiation during health care interactions which will be explained in the following subsection.

6.6.2 Theoretical Category 6: Negotiating Trust

The sixth theoretical category was developed in response to participants' perceptions of the importance of trust in health care interactions. The concept of trust was one which appeared consistently during interviews and informal conversations. In the context of health care relationships, such as between health users and health providers, participants reported feeling different degrees of trust toward different group members, with more trust generally felt with in-group members, such as between community members and CHWs, and less trust felt between community members and health professionals as illustrated by the following two quotes:

"Between us and the community there is much trust. Because we [CHWs] live in the same communities. We know the realities and we act accordingly... We speak to them [community members] with confidence. So they feel trust in us. They tell us everything. Sometimes they even tell us secrets they are keeping from their

husbands or wives. We have a lot of trust in that regard. Because of this, we can act as a sort of spokesperson for them...” (Community Health Worker 2)

“...There’s not really that much trust with them [health professionals]. The people [community members] don’t feel that much trust in them. Sometimes...a lot of times, they [health professionals] do things without explaining. They go right in and do what they want. There is no respect. As a promoter, I have little contact with them, because I know they don’t like to listen. I do know what my community needs though and I try to do what I can to make sure the pregnant women get checked when they need to.” (Community Health Worker 1)

There are positive and negative implications of feeling different degrees of trust toward different group members. In terms of positive implications, feelings of trust between community members and CHWs were interpreted as facilitating feelings of empowerment in the CHW, who could then be enabled to use this empowerment to act as an opinion leader, or spokesperson for the community members’ needs. This could be beneficial for disempowered community members who experience discrimination or exclusion from health services because they would then have a specified person to voice their concerns with. The negative implications, however, might be that the close proximity between community members and CHWs means that CHWs may be more privy to personal or confidential information about the other community members. This could potentially lead to community members withholding vital health information from the CHWs due to fear of stigma or the potential for rumors to spread throughout the community.

CHWs, in turn, feel respected by community members but undervalued by health professionals. Trust between health users and providers was thus interpreted as a process that occurs fluidly and seems to be continuously reassessed during health service interactions. This continual reassessment or “negotiation” occurs as a cognitive process and is influenced by expectations or assumptions over how different groups will behave toward each other. As Calnan and Rowe (2004, p.3) explain, “trust relationships are characterized by one party, the trustor, having positive expectations regarding both the competence of the other party, the trustee, and that they will work in their best interests”. Further, as Carr (2001, p.38) explains, “...trust is built slowly over time as part of a

process, including encountering and appraising the other. Trust may take a while to develop because of both the patient's prior experiences with life in general and with the healthcare system specifically".

Traditionally, greater expectations are placed on the authoritative knowledge of health professionals (Calnan and Rowe 2004). However, trusting relationships can be altered dependent on the organizational structure of medical care and the culture of health care delivery (Calnan and Rowe 2004). In the study area, public attitudes between the different participant groups varied greatly, reflecting inconsistencies in the acceptance of professional knowledge. Community members often exhibited more trust toward the CHWs because they belonged to the same ethnic group. Conversely, health professionals exhibited less trust in the knowledge or abilities of CHWs as indicated by CHWs reporting that health professionals treat them disrespectfully and do not listen to them. Negotiating the levels of trust felt during specific interactions with different social identity groups may thereby be contingent on the expected behaviors between the trustor and the trustee. These levels are likely determined through an active process of decision-making over how interactions between different groups will be handled as will be explained subsequently.

6.6.3 Theoretical Category 7: Facilitating Interactions

The final theoretical category explains how the main role of CHWs, as interpreted in this study, is to facilitate interaction between community members, providers and coordinators of maternal health services. The previous theoretical categories explained potential factors linked to intergroup tensions in the study area (i.e., *Theoretical Category 1: Feeling internal conflict* and *Theoretical Category 2: Being influenced by assumptions*), and the ways in which the social boundaries of exclusion may be crossed (i.e., *Theoretical Category 3: Adopting a Professionalized Identity* and *Theoretical Category 4: Bargaining ethnic identity*). Accordingly, Theoretical Categories 5 and 6, respectively, explained how empowerment and feelings of trust by and towards CHWs may contribute to the enhancement of maternal health service relationships. The final

theoretical category builds on each of the previous theoretical categories to explain the ways in which CHWs can potentially form a vital link between traditionally excluded and non-excluded groups in a population. Equally, the factors which hinder CHWs in facilitating links between groups were found to mainly occur at the health system level and the challenges associated with this will also be discussed.

First, it has been observed throughout this study that CHWs, as located on the periphery of at least two different social identity groups, are uniquely positioned to move between the social boundaries of exclusion, thus ideally facilitating interaction between indigenous community members and non-indigenous health professionals and coordinators of care. One CHW, for example, commented that it was important for the community members to interact with the health professionals providing maternal health services despite the likelihood that they would be treated disrespectfully by health facility staff:

“I help campesinos and health workers interact with each other. I bring them together. They wouldn’t go to their check-ups if they didn’t have someone they could confide in and tell them that it’s alright, they should be strong and just go. I want them to be treated with respect. But sometimes we have to deal with negative attitudes. I tell them to ignore it and be proud of who they are...”
(Community Health Worker 1)

Comments such as this highlight the importance that CHWs place on promoting facility based care in order to ensure a healthy pregnancy, childbirth and postpartum. As CHWs are also community members, they too reported experiences with discrimination and as a result indicated feeling comfortable delivering firsthand advice over how to handle such situations. For example, during an informal conversation conducted during a training workshop in which Community Health Worker 1 was present, she described an instance in which the doctors and nurses at the village hospital laughed at her and then ignored her when she tried to explain why one of her fellow community members was not attending her pre-natal visits. As she recalled, she felt the health professionals were rude to her and did not take her seriously because she was from the community. However, she responded positively when asked if she felt that being a CHW could help her avoid

discrimination, explaining that although she did not feel as though the discrimination would ever go away, but that at least being a CHW gave her the confidence to continue to talk to the health professionals despite feeling ignored as well as to encourage women to go to the health facilities when required. CHWs may then become enabled to challenge discrimination through gained feelings of confidence however only to the extent that an individual is willing to accept poor treatment from health professionals. Accordingly, as the above examples indicate, CHWs can provide helpful advice to their fellow community members and encourage the community women to visit the health facilities if and when needed. In this regard, CHWs may be enhancing the accessibility of services, however there may still be limitations in their ability to address disrespectful care. As such, not all CHWs reported positive experiences providing care to the communities. One particular CHW explained how the added responsibility of being a CHW made her feel burdened:

“...yes...it worries me. Sometimes someone will come to me in the middle of the night with a problem. I don’t always know the right things to do...but I do say that the doctor will know what to do. I was scared that [the community member] would be angry with me though, for not having the medicine...but because of this, it is important to see the doctor. I told him this.” (Community Health Worker 5)

As such, this CHW described how she would worry that the other community members would get angry with her if she did not have a sufficient supply of medicines or if she was unsure how best to treat an ailment presented to her. By taking on the role of a referral system, however, this CHW is indirectly facilitating interaction between the community member and the health facility, despite the potential negative effects (i.e., the community member becoming angry at her).

The health professionals similarly described instances of CHWs bringing groups together. A health center nurse for example described one particular event where two CHWs from Community 1 visited her in the health center to complain about the poor treatment one of their fellow community members had received. The CHWs reported that a woman from their community was yelled at during a health facility visit, however

the health center nurse found this behavior to be unacceptable and advised the CHWs to ensure that the woman continue seeking formal health services despite having received disrespectful care:

“When they came to see me, they said that [woman from Community 1] was yelled at during her visit because she had too many pregnancies. It was one of the technical nurses that yelled at her...I don’t tolerate this behavior. They shouldn’t tolerate this behavior. I told the CHWs to tell [woman from Community 1] to come see us [mobile health team] in the [village hall] on this Friday [during a mobile health visit].” (Health Center Nurse 1)

This quote demonstrates another example of how CHWs can be used to relay information between the community members and health professionals. This is particularly useful because the community woman would not likely have gone to see the health center nurse during the mobile health visit if the CHWs did not raise awareness that she might need a further health consultation.

The examples from the data thus indicate that a key role of CHWs is to facilitate interaction between excluded or marginalized community members with health providers, yet this is often hindered by weaknesses at the health system level. As such, though CHWs may be useful for positively influencing the accessibility of maternal health services, challenges remain in influencing the quality of care. Accordingly, linking the communities to health facilities through the processes of adopting the professionalized identity of CHW, ethnic bargaining, empowerment and trust negotiation may possibly help indigenous Andean *CHWs* overcome barriers to maternal health services characterized by the social boundaries of exclusion. The challenges for CHWs to enact this role in order to help their fellow *community members* overcome these barriers, however, lies in promoting collaboration between the different participant groups, in particular amongst the socially dominant group (i.e., non-indigenous providers and coordinators of care) who have an influence in how the health system is carried out. Thus, if CHWs are indeed enabled to utilize bargained ethnicity to overcome barriers to care, therefore facilitating access to services, it would be equally necessary for the health system to address the root causes of indigenous exclusion from maternal

health services (i.e., those characterized by the social boundaries of exclusion), in order to ensure greater quality of care for indigenous Andean women and their families. The substantive grounded theory presented above has therefore been developed to identify the role of CHWs in providing maternal health services, and in turn, whether and to what extent they would be enabled to assist Andean community members in need of maternal health services to overcome the social boundaries of exclusion.

6.7 Conclusion

Drawing from the findings provided in the previous chapter, this chapter further develops the analysis and presents a substantive grounded theory constructed from the analyzed study findings. The theory that was developed was intended to explain whether and to what extent the CHWs in the study area can become enabled to cross or blur the social boundaries of exclusion through a process of ethnic bargaining and professionalization. In accordance with the tenets of constructivist grounded theory, the substantive theory provided in this chapter was constructed through inductively establishing a set of theoretical categories grounded in the data as the study progressed. This chapter has therefore provided a summary of the substantive grounded theory followed by a discussion of each of its categories and how they correspond to the development of the theory. The following chapter discusses some implications of the study findings and provides recommendations for further research, thus concluding this thesis.

Chapter 7: Conclusion and Recommendations

7.1 Introduction

The final chapter of this thesis reflects on the potential implications of the study findings and provides some recommendations for policy makers, health professionals, and social development program coordinators. These recommendations are presented with the aim to guide further research which could influence decision makers and other key players in the context of improving the accessibility, acceptability and quality of maternal health services in Andean communities of Cusco. This chapter thus begins with a brief summary of the main points of this thesis (7.2). This is followed by an evaluation of the grounded theory which was constructed (7.3). Section 7.4 discusses the original contribution to knowledge, highlighting both theoretical and empirical contributions of this study. Recommendations are then provided in Section 7.5. Section 7.6 concludes this thesis.

7.2 Thesis Overview

This thesis was developed with the overall aim to identify whether and to what extent CHWs living and working in rural highland communities of the Southern Peruvian Andes might be enabled to facilitate interaction between excluded and non-excluded groups as a way to contribute to improving the accessibility, acceptability and quality of maternal health services. CHWs were chosen as the focus for this study out of an intrinsic interest in their role as potential boundary crossers. As has been explained throughout this thesis, Peru is a country with a vastly diverse population. Social exclusion and discrimination against the indigenous population leading to barriers to quality maternal health services have been identified as dominant societal concerns. The potential for CHWs to facilitate interaction between indigenous community members and health professionals or coordinators of care as a means to positively influence the way maternal health services are experienced was thus also identified in the early stages of this study. Although CHWs have a relatively strong presence in the maternal health literature base, studies focusing on the role of CHWs in Andean communities of Peru are

vastly limited. This study was therefore developed with the intent to provide an interpretive account of the social processes driving exclusion in the study area and the potential role of CHWs in influencing the way maternal health services are experienced and managed by the different participants of the study.

A combined grounded theory and case study approach has proven useful in a country such as Peru that is characterized by such a vast multiethnic and multicultural population. The inductive nature of this approach facilitated a means for understanding how an individual's self-identity and corresponding group identity may or may not influence the ways different groups perceive themselves and others, and in turn, how they then behave and interact toward members of other social identity groups. Given the social inequalities many indigenous Andean women and their families still face, in particular during the maternity period, this study has identified how the socio-historical development of micro-level individual and group identities can contribute to macro-level aspects of exclusion, such as institutionalized racism within the health services. Consequently, it was observed that the process of ethnic bargaining may be a useful mechanism for overcoming exclusion and thereby also potentially facilitating social mobility. The tendency to turn to ethnic bargaining for strategic social mobility purposes in itself highlights the deeply embedded racism present in Peruvian society and its institutions. Therefore, although ethnic bargaining may be useful, it has the potential ramification of perpetuating further institutionalized racism. As such, addressing the root causes of social exclusion and how these are reflected in institutions such as the health system need to be emphasized, rather than relying on individualistic approaches to social mobility (e.g., ethnic bargaining).

7.3 Evaluation of the Grounded Theory

The following subsections provide some reflections on the methodology used to conduct this study.

7.3.1 Applying the Grounded Theory to Answer the Research Questions

First, the main research question, which was intended to define the overall objective of the study, asked:

In what ways can the indigenous identities of CHWs be negotiated to overcome barriers to maternal health services in Cusco's rural Andean communities?

In accordance with the data as interpreted in this study, indigenous Andeans who take on the professional responsibilities of their role can potentially be enabled to adopt a professionalized identity. This identity would exist in addition to any other social identities which they may already bear (e.g., ethnic or cultural). Generally in the study region, having the professionalized identity of a CHW is associated with a number of assumptions. For instance, the person has some degree of education, the person has a working knowledge of Spanish and that the person is likely somehow connected to those in power and can therefore act as a spokesperson for community needs.

Once they are identified by others with this new professionalized identity, they may thus be more likely to be associated with others who hold similar, but more advanced roles, such as health professionals. At this point the possibility for ethnic bargaining increases. As health professionals in rural Andean regions are educated in urban areas, they are more likely to either self-identify as non-indigenous or have had some contact with large populations of non-indigenous people. Therefore, by belonging to the social identity group associated with their new professionalized role, they too might be more privy to adopting the behaviors of other similar social identity groups (e.g., varying cadres of health professionals). Having interaction with members of higher status identity groups, such as non-indigenous health professionals may then facilitate the process of negotiating which identity to emphasize or de-emphasize. In this way they can negotiate their strength of identification towards indigenous or non-indigenous identity depending on the context of the situation and the aims of the interaction occurring. For instance, if a CHW is in a situation where he or she is accompanying a community member to a health facility, the CHW may be able to emphasize the specific norms and attributes

associated with the non-indigenous identity group (i.e., health professionals) in order to enhance the likelihood that they will be treated more respectfully during the health service interaction. Equally, the CHW may choose to emphasize his or her indigenous identity when interacting with members of their own ethnic identity group (i.e., other community members) in order to enhance the relationships and trust exchanged between each. For example if a CHW is attempting to convince a fellow community member to visit the health facility despite the poor treatment he or she is expected to receive, the CHW may refer to some of their shared social and cultural norms in order to augment feelings of comradery and therefore trust in the CHW.

Pragmatically bargaining ethnic identity was thus identified as an important mechanism for facilitating interaction between different social identity groups who traditionally hold uneven power relationships. The indigenous identities of CHWs can thereby be negotiated by either emphasizing or de-emphasizing their “indigeneity” depending on who the interaction is with, and what the intended outcome of the interaction will be. This is certainly not to say that one identity is more valid than another, or that CHWs or other indigenous Andeans should strive to assimilate into non-indigenous social identity groups, however this question is intended to point out the strategic use of identity bargaining in a setting where indigenous exclusion is commonplace (See Figure 28 for a visual representation of how CHWs are situated to link the different social identity groups comprising the different participant groups of this study).

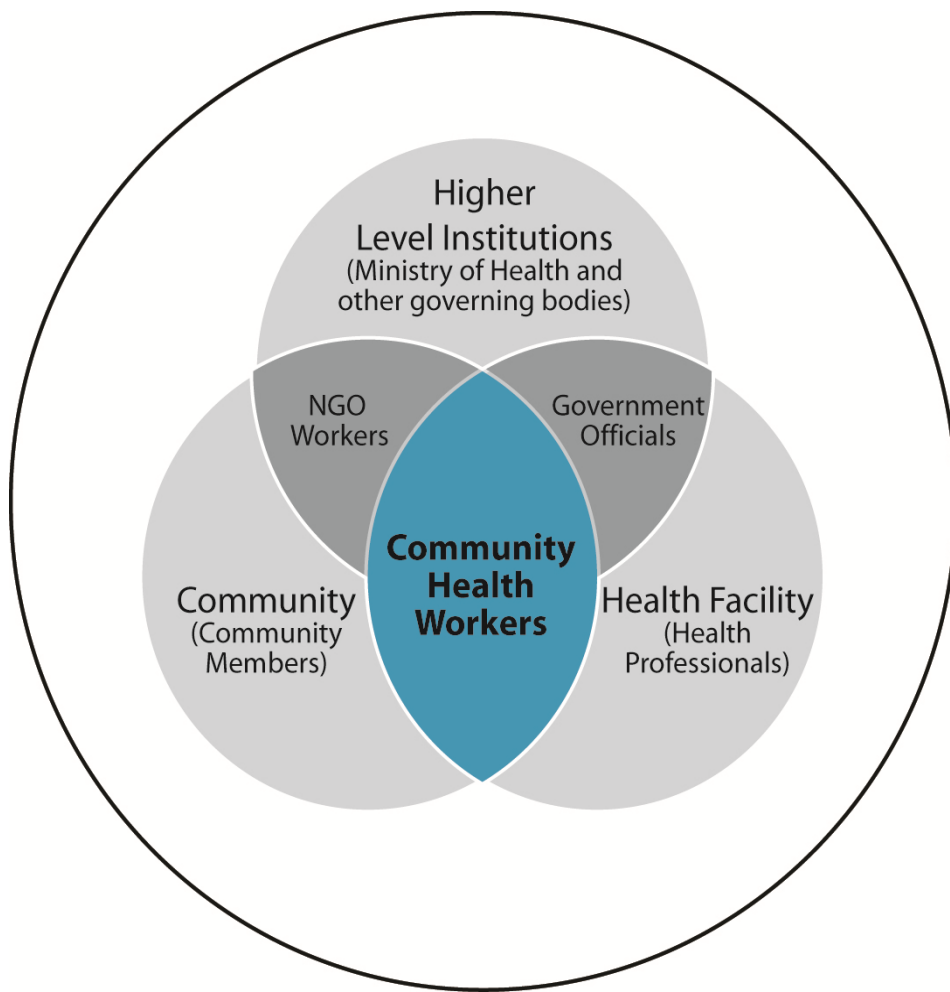


Figure 28: Diagram of the different participant groups

The following four sub-questions were intended to map out the research setting and provide the background and context of the research problem. Accordingly, these were:

- 1. In what ways are maternal health services provided and utilized in the study area?**

Health facilities in Peru are dominated by a biomedical approach to care. As such, maternity services are carried out in health facilities and follow a predominantly medicalized approach. Medical pluralism does, however, exist within Peru's health system. The majority of indigenous Andeans hold very specific beliefs about pregnancy,

childbirth and the postpartum which do not coincide with the Western biomedical approach characterizing Peru's modern health system. As a result of underutilization of formal maternal health services, the Peruvian government implemented a policy to ensure culturally adapted birthing services (e.g., vertical birthing) were readily available to indigenous women. Nonetheless, many barriers to care have been identified in this study, which continue to hinder the accessibility, acceptability and quality of maternal health services. Such barriers to care are generally attributed to the social boundaries of exclusion as discussed in Chapters 5 and 6 of this thesis. Maternal health services for rural indigenous women and their families thus need significant structural and systemic improvement in such a way that would address the social boundaries of exclusion if they are to improve MMR rates and prevent unnecessary deaths or complications during pregnancy, childbirth or postpartum.

2. What is the role of CHWs in providing these services?

The main role identified for CHWs in this study was to act as a link between community members, providers and coordinators of formal maternal health services. CHWs who are strongly supported by their fellow community members, the health system and coordinators of care may be more likely to facilitate interaction between groups who have historically tense or exclusionary relationships, such as indigenous Andeans and other non-indigenous ethnic groups. Given that CHWs are situated on the peripheries of multiple social identity groups, they can be in the unique position to create and strengthen links between community members and health providers, because they themselves may likely have stronger associations with both groups. As such, according to the study findings, CHWs hold several responsibilities in terms of maternal health which they are expected to carry out. These are:

Individual Level	Family Level	Community Level	Institutional Level

Care for their own health and their family's health.	Monitoring women and children's height and weight.	Act as a community spokesperson.	Act as a community spokesperson.
Ensure community women are attending their check-ups at the health facilities.	Making home visits.	Participate in educational communication activities in the community.	Ensure health facility staff are treating community members respectfully and offering high quality care.
Ensure community women are informed about culturally adapted birthing services in health facilities.	Monitoring personal and household hygiene.	Educate the community in proper nutrition.	Liaise with municipal government workers to ensure community development programs are meeting the needs of the communities.
Provide guidance to family members about health care.	Mapping out and Monitoring high risk families.	Organize neighborhood watch activities.	Liaise with NGO workers to ensure community development programs are aimed to minimize exclusion from maternal health and
Promote personal hygiene habits and sanitation: hand washing, tooth brushing, disposal of trash and waste.	Promote healthy pregnancy.	Participate in the community referral system.	
Maintain records of basic health information at the	Ensure pregnant women are getting proper nutrition.	Motivate the community to participate in physical activities to ensure current and future health.	
	Lactation support and promotion.	Motivate the community to	
	Promote the healthy habits among families.		
	Maintain records of basic health information of community		

individual level.	members. Identify and report any instances of physical or emotional abuse occurring at the family level.	avoid the consumption of tobacco, alcohol and drugs. Support activities for learning health habits and values within the community.	other social services.
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Table 5: Expected responsibilities of Andean CHWs

CHWs therefore have several tasks and responsibilities they are expected to perform. As they are community members themselves, yet also act as frontline health providers, they are often the first point of contact for community members needing care. Accordingly, another main role is to act as a referral system between community members and other providers or coordinators of care. Being enabled to move (somewhat) freely between both of these identity groups places them in this valuable position where they can create and strengthen links between community members and the formal health system, with the added benefit of potentially crossing the social boundaries of exclusion while assisting others to also cross these boundaries. However, as discussed throughout this thesis, challenges for CHWs to enact this role have also been identified as will be discussed below.

3. What are the main challenges as identified by participants for CHWs in enhancing the accessibility, availability and quality of maternal health services to community members?

Institutionalized racism, as characterized by the social boundaries of exclusion was identified as one of the main barriers hindering the accessibility, acceptability and quality of maternal health services. The CHWs who participated in this study all expressed determination to help their fellow community members overcome these barriers, however, there were many obstacles preventing their success. Geographic distances, lack of remuneration, and feeling disrespected by health professionals all contributed to these obstacles. For instance, as described throughout this thesis, CHWs were expected to attend monthly training workshops jointly coordinated by government officials, NGOs and health facility staff. These workshops usually took place in the village health facility which is often a significant geographical distance away from many of the communities. However, the workshops often started several hours after the indicated start time, or in some instances were cancelled all together without notifying the CHWs prior to cancellation. As a result, the CHWs who were able to make the journey to the village would lose valuable time that could have otherwise been spent working in the fields. Those who attended workshops which were carried out, often had to endure long days without lunch or reimbursement for travel expenses. Such inconsistencies in organizing and carrying out workshops may be indicative of CHWs not being taken seriously by health professionals or coordinators of maternal health improvement programs. As has been discussed throughout this thesis, health professionals have sometimes reportedly treated CHWs with disrespect because they did not often trust or have confidence in the knowledge or abilities of the CHWs.

Similarly, at the community level, some community members would reportedly withhold information from the CHWs for fear of stigma, gossip or negative judgment. Additionally, the added responsibilities of being a CHW may lead to fear of being treated poorly by the other community members in instances of not having sufficient medicines or knowledge, or of no longer being considered a community member once they have the expert knowledge of a higher status social identity group. At the same time, however, community members might not have enough trust in the authoritative knowledge of the CHW and therefore abstain from utilizing their services. The main

challenges for CHWs can thus be attributed to the way they are perceived by each of the different social identity groups they interact with.

4. To what extent has the indigenous identity of the CHWs been a factor in facilitating interaction between indigenous Andean community members and providers and coordinators of formal maternal health services in the study area?

The final sub-question was finalized once the last two theoretical categories, “negotiating trust” and “navigating interactions” were developed. As described in subsection 6.6.2 of this chapter, the process of negotiating trust occurred fluidly and seemed to be continually reassessed during health service interactions. Given the intergroup tensions existing between indigenous Andean community members and non-indigenous Andean health providers and coordinators of care, trusting relationships seemed few and far between. CHWs may therefore be a useful linking mechanism between these groups. By acknowledging the empowerment and authority that accompanies the professional role of CHW, they are enabled to act as a community spokesperson and potentially serve as an agent of change for their communities. Indigenous Andean community members and non-indigenous providers and coordinators of care who would otherwise avoid each other can therefore potentially be brought together by the CHW given their unique role as a boundary crosser. As has been discussed in this study, the data has indicated that the process of ethnic bargaining may have been present among some of the participants’ interactions. This was particularly evident among the CHW group who, by their role as potential boundary crossers, had more interactions with different ethnic groups. The process of ethnic bargaining may have thus been implemented as a way to overcome discrimination from the socially dominant identity group with the potential benefit of also facilitating the social mobility of the CHWs. In this way, CHWs may be enabled to cross the social boundaries of exclusion, however the extent to which they are enabled to assist their fellow community members reach quality maternal health services rests on strengthening the social, structural and systemic weaknesses of the health services.

7.3.2 Credibility and Originality

Credibility for this study is reflected by the familiarity the researcher gained in the study topic. This has been achieved through extensive immersion in the data, as guided by the tenets of constructivist grounded theory. Although issues of practicality (e.g., time and financial constraints) limited the time spent in the field site collecting data, the analysis methods outlined by Charmaz (2006), such as coding, constant comparison and memo-writing ensured a certain degree of intimacy with the data was reached. Close analysis of the collected data resulted in the development of the theoretical categories comprising the substantive grounded theory. As such this thesis is intended to act as a link between the data and the theory in order to provide some insights into the underlying social processes contributing to the study problem. Given the emphasis on applying symbolic interactionism to make sense of the raw data, the substantive theory is thus intended to reflect the experiences and perceptions of the participants as interpreted by the author of this study.

This study was therefore developed with the goal to offer new and original insights into a topic that has been identified as having a significant literature gap. Improving maternal health and decreasing maternal mortality and morbidity worldwide has been a top priority in many countries, particularly as the 2015 MDG deadline is reached. As has been described throughout this thesis, CHW programs have been both applauded and criticized in various regions. However, despite the inclusion of CHW programs in Peru's national health strategy, there have been significantly few studies into whether or in what ways Andean CHWs may either contribute or hinder the improvement of maternal health services.

By identifying the various social and structural determinants of poor maternal health outcomes, this study has examined how community level approaches to improving the accessibility, acceptability and quality of care, such as CHWs, can potentially influence maternal health outcomes. As such, the role of CHWs as boundary crossers has been highlighted in order to demonstrate the importance of including indigenous frontline

providers of care to minimizing the negative effects of institutionalized racism, thereby potentially increasing the utilization and quality of maternal health services. The analysis of the data offered a unique way to conceptualize the experiences of indigenous Andean community members, CHWs and non-indigenous health professionals and coordinators of maternal health improvement programs. This original approach has thus highlighted the ways in which the fluidity of various social identities can be pragmatically utilized to facilitate social mobility. Originality for this study was thereby enhanced by contributing to the significant gap in research concerning Andean CHWs in Peru, while also examining indigenous identity constructions in the Andes and how these are experienced and managed in the study region.

7.3.3 Limitations

As with all research, several limitations were encountered throughout the course of this study. In addition to data collection limitations as discussed in Chapter 4, Section 4.9, some theoretical limitations were also identified. First, consistent with constructivist grounded theory, this study provides an interpretation of the data that is specific to the study area. It can be argued that the usefulness of this study can be limited without a greater degree of generalizability, however, as has been described throughout Chapter 4 of this thesis, this study does not assume generalizability. Instead the goal is to provide a starting point for further development and refinement in subsequent studies. As such, the conceptual interpretation of the occurring social processes explained by the substantive grounded theory could potentially be useful to transfer to other closely related contexts.

Perhaps the most significant limitation, however, was the lack of existing literature itself. Given the scarcity of Andean CHW research in Peru, this study was limited to identifying conceptual frameworks closely related to the topics in question, which may not have been specifically geared towards such topics. In this regard, several theories, mainly those specific to the social sciences (e.g., social exclusion, boundary crossing, identity construction), were drawn together and integrated in order to identify patterns leading to the specific study problem. While this has indeed brought limitations to this

study in terms of potentially delimiting credibility or generalizability, it can be argued that this approach may be useful for gaining a fresh and unique perspective on community approaches to improving maternal health services in rural Andean communities.

7.4 Original Contribution to Knowledge

While generalizability was not the main goal of this thesis, this study has been successful in producing both theoretical and empirical contributions to knowledge which may be useful for the development of future policies and practices. Firstly, this study contributes to theoretical and empirical understandings of the relationship between social exclusion, institutionalized discrimination, racism, and access to health services. In terms of theory, this study has emphasized that individuals do sometimes undertake a form of ethnic categorizing and thus ethnic bargaining. However, the occurrence of these processes among the participants of this study affirms the presence of a significant social problem – that discrimination and racism, particularly within institutions such as the health system is deeply engrained in Peruvian society. Using ethnic bargaining as a coping mechanism may therefore be an indication of how widely accepted discrimination and racism against the indigenous population is. This “culture of submission” as explained in Section 6.6.1 of the previous chapter – where marginalized groups accept poor or disrespectful treatment as simply the status quo – very much needs to be highlighted and addressed both in academic literature as well as in future policies and interventions aimed to improve Andean health.

Empirically, this study offers a starting point to understand the potential contributions CHWs can make towards improving maternal health in Andean communities. For instance, if CHWs are the first point of contact for community members in need of maternal health services, then there should be greater attention on identifying who these actors are and what their expected and actual roles should be, in order to strengthen the services, they are able to provide. Of particular concern is the potential CHWs have to navigate between conflicting models of health care. As discussed throughout this thesis,

the Peruvian health system operates under a western biomedical approach to care. As indigenous community members, CHWs are aware of traditional healing methods and therefore are more familiar with the circumstances that might arise when these methods would be preferred. Similar to Jenkins' (2011) study of health promoters in a low-income settlement in the outskirts of Lima, this study asserts that CHWs who can successfully balance or negotiate their ethnic and professional identities might be more able to navigate the tensions between the two conflicting healthcare models. Further, the CHWs in this study provided care to the community members that incorporated elements from both models as evidenced by the process of boundary crossing. For instance, the community members expected the CHWs to be respectful of traditional birthing preferences, however they were equally mindful of the CHWs advice to attend their pre-natal care appointments. Nonetheless, finding a way to balance both models can be both positive and negative for improving maternal health care in Andean communities. The positive implications are that CHWs can focus on their shared socio-cultural beliefs and expectations to promote good health for would-be mothers. On the other hand, a potential negative implication is that CHWs may not have sufficient medical knowledge to treat women who might experience complications, and therefore may be more susceptible to promoting behavior which is not medically recommended, such as in the example where the CHW advised a woman to feed her newborn tea rather than the colostrum as described at the end of Section 6.5 of the previous chapter.

Another main contribution this study offers is to build on the current literature base on CHWs in the Peruvian Andes. As discussed throughout this thesis, there is very limited research into the role or experiences of Peru's CHWs. As described in both Chapter 2, Section 2.5.2 and Chapter 3, Section 3.7 of this thesis, successful CHW programs require strong government support as well as community participation, however there is often limited information on the specific strategies used to enhance the programs. This thesis therefore contributes to the literature on potential factors that influence whether a CHW program is successful or not. In this study for example, the factors which were viewed positively were in the CHWs' abilities to link their fellow community members

to the wider health system by navigating between their own socio-cultural understandings and expectations and those of the dominant social class (i.e., non-indigenous community members). Building on the research presented in various key reports and articles, such as those by Physicians for Human Rights (2007), Amnesty International (2009a; 2009b), Bristol (2009), and Brown (2006), this study has aimed to advance current understandings of why poor maternal health continues to be a significant problem in indigenous Andean communities. Ethnic based exclusion leading to tensions between maternal health service users and providers of care has thus been identified as a problem that is very specific to the Peruvian context. While all of the social determinants for health described throughout this thesis have an impact on maternal health care in excluded and marginalized communities of the Andes, the role of ethnic exclusion has been highlighted as the most detrimental. Ethnic exclusion is so rampant in Peruvian society it is often taken for granted and subsequently “hidden in plain sight”, often in institutions specifically aimed to help people, such as the health system. It is therefore extremely important to recognize ways to uncover failures in Peru’s health system, such as those attributed to institutionalized discrimination (and societal racism in general) in order to develop future policies and practices which may help improve maternal health services for the indigenous population. The following section provides some recommendations.

7.5 Recommendations for Policy and Practice

Addressing barriers to maternal health services requires dedicated actions from each of the stakeholders involved. Lack of available, accessible and acceptable maternal health services in rural Andean communities should be the responsibility of all involved, from the potential service users, to the providers and coordinators of care. As such, social development programs coordinated by regional municipal government workers should work closely with policymakers, social development project coordinators, health professionals, CHWs and the community members themselves to ensure that health care interventions are adequately designed to meet the needs and rights of the population they are aimed for. Further, these programs should strive to promote the availability,

acceptability and quality of maternal health services, with particular emphasis on respectful care and minimizing the social boundaries of exclusion. Programs should therefore be developed which address institutionalized racism, which is essentially the core of the social boundaries of exclusion.

It would be important for health professionals and government officials working in the municipal offices to ensure that there is accountability and transparency in all dealings with community affairs. Further, having an appointed community member, such as the CHW, to liaise between the communities and providers and coordinators of care could also be beneficial. As ethnic and gender based discrimination is deeply ingrained in Peruvian society, approaches that emphasize sensitization to indigenous culture should be emphasized. This may be achieved through training community members, health professionals and coordinators of care to be sensitive to the specific health needs of indigenous community members. These trainings would be more likely to succeed if human rights or gendered approaches to development issues are explicitly included. Likewise, in order to minimize ethnic and gender based discrimination during the provision of care, health professionals should be sensitized to the specific cultural attitudes and beliefs of indigenous Andeans. Ideally, this should also occur at the training level. As such, education systems should strive to strengthen cultural awareness education for future health professionals, so that they are aware of the specific traditional and cultural preferences of indigenous Andeans. Accountability measures should also be put in place to ensure that health facilities are in fact offering indigenous Andean women the option for vertical birthing or other integrated services. Further, they should ensure that indigenous Andean women and their families are informed that this option is available and that they have the right to choose which method to use.

As CHWs were identified in this study as a potentially important link between community members and the other stakeholders invested in improving maternal health outcomes in the study area, there should be emphasis on strengthening the weaknesses in CHW programs. CHWs can ideally be considered an example of an empowered social network with the capacity to negotiate the social boundaries of exclusion in order to

enhance social mobility. By providing support to health personnel and acting as frontline providers of care, CHWs could thereby be a valuable resource. Clearly identifying their roles within the communities and the health system should thus be a primary concern in order to enhance their potential to facilitate interaction between the two. As such, finding alternative community oriented ways to cross boundaries may be more successful and sustainable than relying on individualistic approaches to social mobility, such as professionalization or ethnic bargaining. It is important to note that this study has purposely applied a social identity approach as just one way to highlight how micro-level factors such as identity categorizations based on a shared socio-historical experience may give rise to macro-level occurrences, such as institutionalized racism or uneven power relationships within the health system, and consequently how this is managed at the community level. Further studies applying community participation approaches could, therefore, be a useful starting point to illuminate additional methods for community approaches to overcoming exclusion from maternal health services.

7.6 Concluding Remarks

This study found that fostering positive relationships between the different participant groups of this study (characterized by their specific social identity groups) may be a valuable method to improve the way maternal health services are experienced in rural communities of the Cusco region of Peru. This study has therefore examined the potential for CHWs to act as boundary crossers in order facilitate interaction between community members, health providers and coordinators of care. The substantive grounded theory has provided an interpretive account of the social processes contributing to exclusion from maternal health services and the potential for indigenous Andean CHWs to either cross, or enable others to cross, the social boundaries of exclusion. As has been described in this concluding chapter, this study is intended as a starting point for which subsequent studies can be based in order to enhance the literature on the role of CHWs as frontline providers of care in Peru's rural Andean communities. The recommendations presented in this chapter further highlight the topics which could benefit from expansion in order to gain a more comprehensive and robust

understanding of the potential role of CHWs in the study area. This could thus be extremely beneficial for future recommendations to decision makers and other key players who have an influence on the social, structural and institutional barriers to care and how these can be minimized as a means to improve maternal health outcomes amongst socially excluded and marginalized groups such as indigenous Andeans.

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Appendix 1: Research Fieldwork Plan

November 2011

- Arrive in Lima
- Arrange meeting with representatives from NGOs
- Arrange meeting with MINSA representatives
- Establish contact with other Lima based NGOs that have maternal health and CHW programs to identify additional potential participants
- Begin Lima based data collection
- On-going data analysis

December 2011 – March 2012

- Travel to regional locations for data collection (Cusco)
- Recruit local participants and continue data collection
- Ongoing data analysis

March – April 2012

- Continue regional and Lima based data collection if necessary
- Return to Edinburgh

April 2012 – End of study

- Concurrent analysis and write-up

Appendix 2: Ethical Approval Notification

Vidal, Nicole

From: Martin, Dawn
Sent: 13 September 2011 11:37
To: Vidal, Nicole
Cc: Research Ethics; Fustukian, Suzanne; de Kok, Bregje
Subject: Confirmation of approval

Dear Nicole

Ethical Approval: Crossing Boundaries for Maternal Health: A Qualitative Study Investigating the Role of Community Health Workers in Providing Postpartum Care to Indigenous Communities in the Peruvian Andes

Thank you for your response dated 8 September 2011 to the letter sent following consideration of your application by the Research Ethics Panel.

Dr Jane McKenzie, Convener of the Panel, has reviewed your response to the points you were required to address, and has confirmed that she is happy to take Convener's Action to grant full ethical approval for your research. In granting approval, it is noted that informed consent will not be gained from all subjects being observed for research purposes. However, the Panel is satisfied that every attempt will be made to gain consent where possible and also that the nature of the observation can allow for this deviation from normal ethical requirements.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Panel are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. Please see the link below to the appropriate form for this:

<http://www.qmu.ac.uk/quality/rs/default.htm#ethics>

Please let me know if you need a signed hard copy confirming approval, and I will arrange that.

All the best for the project.

Regards

Dawn

Dawn Martin
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From its very inception, Queen Margaret University, Edinburgh, has focused on providing relevant education and research, addressing real-life issues to enhance the social and economic well-being of all the communities we serve. We have expertise in: health; media; communication; performing arts; social sciences; and business, management and enterprise. As a small university, we aim to offer a community



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7 September 2011

Dear Nicole

Request for Ethical Approval for a Research Project – Crossing Boundaries for Maternal Health: A Qualitative Study Investigating the Role of Community Health Workers in Providing Postpartum Care to Indigenous Communities in the Peruvian Andes

The Research Ethics Panel has considered your application for ethical approval for the above research project. The Panel's feedback was largely very positive, and you are commended on the obvious care and attention given to ethical considerations, as well as the way in which the application has been completed.

The Panel agreed that the following points should be adequately addressed in a response to the Convener before ethical approval could be granted.

Section 14: It is stated that 'participant-observation will be used throughout the data collection process, provided prior permission is granted by key participants.' Please indicate who 'key' participants are, how they will be identified and how informed consent and ethical oversight is going to be addressed/guaranteed for 'non' key participants, where applicable.

Section 14: You are asked to consider how confidentiality and anonymity will be guaranteed in the unlikely event of recording equipment becoming lost or stolen. Specifically, assurance is sought that digital recordings will be stored immediately on 'password'-protected media to minimise the risk of voices being recognised by individuals external to the research.

Sections 24–27 Although remote, there is a risk of psychological stress to some of the participants. You are therefore asked to consider how you will deal with any adverse participant reactions. Specifically, the Panel would need to know: a) whether you have sufficient experience of this type of situation for it to be managed effectively; and b) whether there might be a need or feasibility for an immediate referral system (as mentioned elsewhere in your application) to more experienced supporting staff should this type of situation occur.

Section 24: This section indicates that there is a risk that participants may perceive that either participation or non-participation may prejudice their health care. Can a line be



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added to the information sheet indicating that their health care will not be influenced in any way by participation or non-participation in the research?

Please submit the revised documentation along with your written response to the points above directly to me. Assuming that the Convener is happy that the points have been addressed, Convener's Action can be taken to grant full ethical approval.

Yours sincerely

Dawn Martin
Acting Secretary to the Research Ethics Panel

Appendix 3: Participant Consent Form (English)



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Consent Form

“Crossing Boundaries for Maternal Health: A Qualitative Study Investigating the Role of Community Health Workers in Providing Postpartum Care to Indigenous Communities in the Peruvian Andes”

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher

Name of researcher: Nicole Vidal

Address: PhD Research Student, Institute for International Health and
Development, School of Health Sciences
Queen Margaret University, Edinburgh
Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU

Email / Telephone: nvidal@gmu.ac.uk / (+44) 0131 474 0000

Appendix 4: Participant Consent Form (Spanish)



FORMULARIO DE CONSENTIMIENTO PARA PARTICIPAR EN ESTUDIO DE INVESTIGACIÓN Y AUTORIZACION PARA USO Y DIVULGACION DE INFORMACION

TEMA DEL ESTUDIO:

Una investigación cualitativa sobre la atención de salud materna y neonatal con enfoque en las experiencias de los promotores y agentes comunitarios de salud en las comunidades Andinas del Perú.

INVESTIGADORA:

Nicole Vidal Tizón (Antropóloga)
Estudiante de Doctorado en Salud Pública
Instituto de Salud y Desarrollo Internacional,
Universidad de la Reina Margaret,
Edimburgo – Escocia
Reino Unido

LUGAR DONDE SE LLEVARÁ A CABO EL ESTUDIO:

Este estudio se lleva a cabo en las comunidades Andinas que pertenecen a la Provincia Peruana de Calca – Específicamente en las comunidades de los distritos de [REDACTED]

1- INTRODUCCIÓN

Usted ha sido invitado a participar en un estudio de investigación. Antes de que usted decida participar en el estudio por favor lea este formulario cuidadosamente y haga todas las preguntas que tenga, para asegurarse de que entienda los procedimientos del estudio, incluyendo los riesgos y beneficios.

Este formulario de consentimiento puede contener información que usted no está familiarizado. Por favor, solicite a la investigadora que le explique cualquier palabra o

información que usted no entienda claramente. Usted puede llevarse a su casa una copia de este formulario de consentimiento para pensar sobre su participación en este estudio o para discutirlo con la familia o amigos antes de tomar su decisión.

2- PROPÓSITO DEL ESTUDIO:

Este es un estudio que examina los servicios de salud que son disponibles para las mujeres gestantes y sus recién nacidos. El enfoque de este estudio queda en entender el papel y las experiencias de los trabajadores del primer nivel de salud: específicamente los promotores/as de salud y los agentes comunitarios de salud, que viven y trabajan en las comunidades Andinas de Cusco, y en entender las formas en que podrán contribuir al mejoramiento de la salud de las mujeres gestantes y sus recién nacidos.

3- PARTICIPANTES DEL ESTUDIO:

Los participantes elegibles para este estudio serán:

- Agentes Comunitarios de Salud/Promotores/as de Salud
- Mujeres gestantes y/o lactantes
- Coordinadores de programas de promotores de salud
- Médicos, enfermeras, obstetras (o otros miembros del sistema de salud que trabajan directamente con los promotores en el caso de brindar servicios materno/infantiles.

Los participantes deben tener 18 años o más.

4- PROCEDIMIENTOS:

Si usted acepta participar en el estudio, se le preguntará acerca de sus experiencias de:

- Los servicios materno/infantiles
- Su trabajo como promotor/a de salud (en caso de los promotores mismos)
- Su trabajo con los promotores/as de salud (en caso de coordinadores o otros miembros del sistema de salud.

La entrevista durará entre 30 minutos a una hora.

5-RIESGOS O INCOMODIDADES:

Existe un riesgo mínimo de que los temas tratados pueden ser sensibles o incómodos, pero usted tiene el derecho de parar su participación y negarse a continuar con la discusión en cualquier momento.

6- BENEFICIOS

Es probable que usted no reciba ningún beneficio personal por participar en este estudio. Sin embargo, estudios como este mismo, pueden hacer una importante contribución a nuestra

comprensión de las formas en que los trabajadores comunitarios de salud (como los agentes comunitarios o promotores), pueden servir como un gran apoyo a los servicios de salud materna y neonatal en las comunidades Andinas del Perú.

7- COSTOS

No hay ningún costo por participar en este estudio.

8- PRIVACIDAD Y CONFIDENCIALIDAD

Todos los datos serán anónimos tanto como sea posible. Su nombre será reemplazado por un número de participante, y no será posible que usted pueda ser identificado en cualquier informe de los datos recogidos. Sin embargo, los resultados de esta investigación pueden ser publicados en revistas científicas o presentados en reuniones académicas, pero su identidad no será divulgada.

9- PARTICIPACIÓN Y RETIRO VOLUNTARIOS

Su participación es completamente voluntaria y usted no está obligado a participar. Si usted decide participar, usted tendrá la libertad de retirarse del estudio en cualquier momento y no tendría que dar una razón.

10- PREGUNTAS

Si tiene alguna pregunta sobre este estudio o sobre su participación en el mismo, usted puede contactar a la facultad de la universidad donde este estudio se origina:

** NOMBRE Y TELEFONOS DE LA INVESTIGADORA Y ASESORA INDEPENDIENTE*

Nombre de la Investigadora: Nicole Vidal Tizón

Dirección: Institute for International Health and Development,
School of Health Sciences
Queen Margaret University, Edinburgh
Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU
United Kingdom

E-mail / Teléfono: nvidal@qmu.ac.uk / 00 (44) 131 474 0000

Nombre de la Asesora Independiente: Carola Eyber

Dirección: Institute for International Health and Development,
School of Health Sciences
Queen Margaret University, Edinburgh

Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU
United Kingdom

E-mail / Teléfono: ceyber@gmu.ac.uk / 00 (44) 131 474 0000

No firme este consentimiento a menos que usted haya tenido la oportunidad de hacer preguntas y recibir contestaciones satisfactorias para todas sus preguntas.

Si usted firma aceptando participar en este estudio, recibirá una copia firmada y fechada de este documento para usted.

11- CONSENTIMIENTO:

He leído la información provista en este formulario de consentimiento, o se me ha leído de manera adecuada. Todas mis preguntas sobre el estudio y mi participación en este han sido atendidas. Libremente consiento a participar en este estudio de investigación. Autorizo el uso y la divulgación de mi información a las entidades antes mencionadas en este consentimiento para los propósitos descritos anteriormente.

Nombre del/a Participante

Firma del/a Participante

Fecha

Firma de la Investigadora

Fecha

Appendix 5: Information Sheet for CHWs (English)



Queen Margaret University
EDINBURGH

Information Sheet for Potential Participants

My name is Nicole Vidal and I am a Doctoral student from the Institute for International Health and Development in the School of Health Sciences at Queen Margaret University in Edinburgh. As part of my degree course, I am undertaking a research project for my PhD thesis. The title of my project is:

Crossing Boundaries for Maternal Health: A Qualitative Study Investigating the Role of Community Health Workers in Providing Postpartum Care to Indigenous Communities in the Peruvian Andes.

This study will investigate the role of community health workers in providing maternal health services during the postpartum period in Quechua communities of Peru.

I am looking for volunteers to participate in this project. Eligible participants for this study will be community health workers who currently work in rural or semi-rural communities of the Cusco region of Peru, and who provide care to women and their families during the postpartum period. Participants must be age 18 or over.

If you agree to participate in the study, you will be asked about your experiences working as a community health worker providing postpartum care services. There is minimal risk that topics discussed may be of a sensitive nature; however you may decline to proceed with the discussion at any time. The whole procedure should take no longer than one hour. Your participation is completely voluntary and you are not obliged to take part. If you do decide to participate, you will be free to withdraw from the study at any stage and you would not have to give a reason.

All data will be anonymised as much as possible. Your name will be replaced with a participant number, and it will not be possible for you to be identified in any reporting of the data gathered.

While there will be no direct benefit from participation, studies such as this can make an important contribution to our understanding of the ways in which community health workers may improve maternal health outcomes in Quechua communities of Peru.

Please further note, health care and services will not be influenced in any way by either participating or not participating in this study.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Carola Eyber. Her contact details are given below.

If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

Contact details of the researcher

Name of researcher: Nicole Vidal

Address: PhD Student, Institute for International Health and
Development, School of Health Sciences
Queen Margaret University, Edinburgh
Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU
United Kingdom

Email / Telephone: nvidal@qmu.ac.uk / (+44) 0131 474 0000

Contact details of the independent adviser

Name of adviser: Carola Eyber

Address: Institute for International Health and Development, School of
Health Sciences
Queen Margaret University, Edinburgh
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Musselburgh
East Lothian EH21 6UU

Email / Telephone: ceyber@qmu.ac.uk / (+44) 0131 474 0000

Appendix 6: Information Sheet for Non-CHW Participants (English)



Queen Margaret University
EDINBURGH

Information Sheet for Potential Participants

My name is Nicole Vidal and I am a Doctoral student from the Institute for International Health and Development in the School of Health Sciences at Queen Margaret University in Edinburgh, UK. As part of my degree course, I am undertaking a research project for my PhD thesis. The title of my project is:

Crossing Boundaries for Maternal Health: A Qualitative Study Investigating the Role of Community Health Workers in Providing Postpartum Care to Indigenous Communities in the Peruvian Andes.

This study will investigate the role of community health workers in providing maternal health services during the postpartum period in Quechua communities of Peru.

I am looking for volunteers to participate in this project. I am looking for participants who have either worked with or been attended by a community health worker in the context of providing postpartum care services. If you have worked with or been attended by a community health worker, it is requested that this will have taken place no more than two years prior to participation in this study. For participants who have been attended by a CHW during pregnancy, participants must have completed their pregnancy term no less than six months prior to participation in this study. Participants must be age 18 or over.

If you agree to participate in the study, you will be asked about your experiences working with or being attended by community health workers providing postpartum care services. There is minimal risk that topics discussed may be of a sensitive nature; however you may decline to proceed with the discussion at any time. The whole procedure should take no longer than one hour. Your participation is completely voluntary and you are not obliged to take part. If you do decide to participate, you will be free to withdraw from the study at any stage and you would not have to give a reason.

All data will be anonymised as much as possible. Your name will be replaced with a participant number, and it will not be possible for you to be identified in any reporting of the data gathered.

While there will be no direct benefit from participation, studies such as this can make an important contribution to our understanding of the ways in which community health workers may improve maternal health outcomes in Quechua communities of Peru.

Please further note, health care and services will not be influenced in any way by either participating or not participating in this study.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact Carola Eyber. Her contact details are given below.

If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

Contact details of the researcher

Name of researcher: Nicole Vidal

Address: PhD Student, Institute for International Health and Development, School of Health Sciences
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Contact details of the independent adviser

Name of adviser: Carola Eyber

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Appendix 7: Information Sheet for Potential Participants (Spanish)

The following document was requested by the local municipal government workers who participated in this study for reference purposes only.



Plan de Investigación

TEMA DEL ESTUDIO:

Una investigación descriptiva y explicativa sobre la atención de salud materno-infantil con enfoque en las experiencias de los promotores y agentes comunitarios de salud en las comunidades Andinas del Perú.

INVESTIGADORA:

Nicole Vidal Tizón (Antropóloga)
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Instituto de Salud y Desarrollo Internacional,
Universidad de la Reina Margaret,
Edimburgo – Escocia
Reino Unido

Problema Objeto de la Investigación

Según los datos del Ministerio de Salud (2007), el 27% de las muertes maternas en el Perú se producen durante el embarazo, el 26% durante el parto, y el 46% en el período

postparto. Las causas inmediatas biomédica de las muertes relacionadas con el embarazo en el Perú son la hemorragia, pre eclampsia (hipertensión inducida por embarazo), infecciones, parto obstruido y complicaciones derivadas del aborto (MINSA Perú, Departamento de Epidemiología de 2007, citado en el AI 2009). Las causas subyacentes de estos casos sin embargo se extienden mucho más allá. Dado a razones sociales, geográficas, y culturales, las mujeres de las comunidades campesinas y sus recién nacidos se encuentran en mayor riesgo de sufrir complicaciones durante el parto y posparto (Bristol 2009, PHR 2007).

Las autoridades Peruanas, así como los profesionales del desarrollo internacional y nacional han estado luchando desde hace tiempo para mejorar la salud materno-infantil entre las comunidades campesinas del Perú (Velasco 2008). Por ejemplo, se han hecho esfuerzos por una variedad de actores como el Ministerio de Salud, ONGs, y otros profesionales del desarrollo, para introducir las intervenciones destinadas a promover un mayor acceso a atención obstétrica de emergencia y las prácticas de parto culturalmente sensibles (PHR 2007). Incluidos en estas intervenciones es la implementación de los promotores de salud y agentes comunitarios de salud.

En casos mundiales, utilizando los recursos locales para apoyar los existentes servicios de salud ha sido reconocida como un enfoque importante para la reducción de la tasa de mortalidad materno-infantil en comunidades así que podrían ser reconocidos como excluidos (Brown et al. 2006). En comunidades de bajos recursos, los cuidadores en el hogar y la comunidad se presentan algunas veces como el primer punto de contacto durante el embarazo. Para facilitar el acceso a servicios de salud y su entrega dentro de sus comunidades, la inclusión de los promotores de salud como proveedores del primer nivel de salud y dando apoyo a los proveedores profesionales de salud así pueden crear una conexión vital entre los miembros de la comunidad y otros actores que están invertidos en mejorar la salud materno-infantil.

A pesar de que los promotores de salud se incluyen en el sistema de salud del Perú, no hay mucha información sobre las actividades y experiencias de ellos mismos. Sin embargo, ellos como trabajadores del primer nivel de salud podrían estar directamente involucrados en el desarrollo de las intervenciones a nivel comunitario. Esta falta general de información en torno a las actividades y experiencias de los promotores de salud a pesar de su importancia para la prestación de servicios básicos de las mujeres gestantes, junto con la reconocida necesidad de continuar el desarrollo de proyectos destinados a mejorar la salud materno-infantil proporciona la base de esta investigación.

Objetivo General

El objetivo de esta investigación es examinar los servicios de salud que son disponibles para las mujeres gestantes y sus recién nacidos. El enfoque de este estudio queda en entender el papel y las experiencias de los trabajadores del primer nivel de salud:

específicamente los promotores/as de salud y los agentes comunitarios de salud, que viven y trabajan en las comunidades Andinas de Cusco, y en entender las formas en que podrán contribuir al mejoramiento de la salud de las mujeres gestantes y sus recién nacidos.

Objetivos Específicos

- 1) Identificar cuáles son los servicios disponibles que se presentan a las mujeres gestantes y sus recién nacidos en las comunidades campesinas de este región del Perú.
- 2) Identificar el papel de los promotores/agentes comunitarios en la prestación de estos servicios para las mujeres y sus familias en estas comunidades.
- 3) Explorar lo que los participantes se identifican como los principales retos de los promotores en la prestación de estos servicios a miembros de la comunidad (por ejemplo: las barreras económicas o geográficas, o culturales).
- 4) Explorar la forma en la que los promotores podrán facilitar una interacción, o actuar como un vínculo entre los miembros de comunidades y otras partes interesadas invertido en mejorar la salud materna, como una manera de enfrentar estos desafíos.
- 5) Determinar cómo y en qué condiciones estos vínculos se pueden formar (por ejemplo: identidad profesional compartida, la identidad cultural compartida, u otras experiencias compartidas).

Ámbito Geográfico:

Este estudio se lleva a cabo en las comunidades Andinas que pertenecen a la Provincia Peruana de Calca – Específicamente en las comunidades de los distritos de [REDACTED]

Metodología

Este es un estudio cualitativo que se emplea el método de estudio de casos para examinar el papel y experiencias de los trabajadores del primer nivel de salud: específicamente de los agentes comunitarios de salud y promotores de salud. Los datos serán recogidos a través de un uso combinado de entrevistas semi-estructuradas, observación participante y revisión de documentos.

Los participantes de este estudio consistirán principalmente en los promotores y agentes comunitarios de salud. Las entrevistas también se solicitarán a otras partes interesadas con el fin de garantizar una mejor comprensión de la función, experiencias y

percepciones de los promotores que trabajan en sus propias comunidades. Las partes interesadas pertinentes son las que tienen un interés personal en mejorar la salud materno-infantil en el Perú, y puede incluir cualquier tales miembros de las siguientes categorías: usuarios de los servicios a nivel comunitario (mujeres y sus parejas u otros miembros de la familia presentes durante el ciclo de embarazo) , proveedores de servicios de salud (incluyendo promotores y otros profesionales de servicios de salud), los trabajadores comunitarios de desarrollo, los médicos tradicionales, o los responsables políticos y otros funcionarios del gobierno. Las entrevistas realizadas tratarán de obtener información sobre las experiencias propias de cada participante de los temas tratados.

Las entrevistas serán realizadas durante los meses de Febrero y Marzo, 2012.

Referencias

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Velasco, K. Peru Addresses Indigenous Women's Reproductive Rights. 22-5-2008. RHRealityCheck.org. [online] Available at: <http://www.rhrealitycheck.org/blog/2008/05/21/peru-addresses-indigenous-womens-reproductive-rights> [Accessed November 23 2009].

Appendix 8: Participant Background Information Checklist

Name:
Community:
Occupation:
Self-identified ethnic affiliation:
Age range:
Level of education (if any):
Relationship status:
Children:
Number of pregnancies (if applicable):
Breastfeeding status (if applicable):

Appendix 9: Interview Guides

Questions to CHWs:

1. Can you tell me what kinds of services you provide to women and their families during pregnancy and postpartum?
2. What do you consider the most important service you provide for women and their families during this time?
3. Tell me about what you like most about being a community health worker? Least like?
4. Tell me about your relationship with other health care staff.
5. Tell me about your relationship with other professionals who are involved with the community health worker program that you are apart of.
6. Tell me about your relationship with the other community members (service-users).
7. What would you consider to be some of the challenges you have experienced working as a community health worker?
8. If challenges are identified, is there anything you wish to see change?
9. If you could, in which ways would you address these challenges?
10. Do you ever feel discriminated against in health facilities? At home? In the community? Tell me about this.
11. If so, tell me about the ways you address this.

Questions to community members:

1. Did you visit with a community health worker during pregnancy and postpartum? If so, how many times?
2. Tell me about your most recent visits with a community health worker during this time.
3. What types of services were you provided by the community health worker?
4. What would you consider to be most beneficial to visiting with a community health worker? Least beneficial?
5. Tell me about some of the challenges you faced, if any, in receiving care?
6. Tell me about your relationship with the community health workers in your community.
7. Tell me about your relationship with other health professionals in your community.
8. From whom do you feel most comfortable receiving maternal health services? Why?
9. Do you ever feel discriminated against at home? In the community? At the health facility? Tell me about this.
10. If so, tell me about the ways you address this.

Questions to health practitioners:

1. Tell me what you think are the biggest challenges for women and their families during pregnancy and postpartum.
2. Tell me what you think are the biggest challenges for women and their families in accessing and receiving adequate maternal health care?
3. Do you consider community health workers to be beneficial to improving the availability or utilization of maternal health services? Why or why not?
4. Tell me what you consider to be the role of the CHW in providing maternal health care services?
5. Tell me about your relationship with community health workers.
6. Tell me about your relationship with the community members.
7. Do you have any experiences with seeing community members being treated unfairly? If so, tell me about this.
8. Do you have any ideas about how Andean culture or beliefs may influence health seeking behaviour? If so, tell me about this.
9. Do you feel that community members are excluded from health services? If so, tell me about this.

Questions to project coordinators/NGO workers:

1. Tell me about the community health worker program your organization runs.
2. Tell me about your role in this project.
3. What is your relationship with the community health workers?
4. Tell me what you think are the biggest challenges for women and their families during pregnancy and postpartum.
5. Tell me what you think are the biggest challenges for women and their families in accessing or receiving adequate care during this period?
6. Tell me what you consider to be the role of the CHW in providing maternal health care services?
7. Do you consider community health workers to be beneficial to improving the availability or utilization of maternal health services? Why or why not?
8. Tell me what you think are the biggest challenges for community health workers in providing services.
9. How would you describe the community health worker's relationship with health facility staff?
10. Do you have any experiences with seeing community members being treated unfairly? If so, tell me about this.
11. Do you have any ideas about how Andean culture or beliefs may influence health seeking behaviour? If so, tell me about this.
12. Do you feel that community members are excluded from health services? If so, tell me about this.

Questions to government officials:

1. Tell me about what sorts of contact you have had with community health workers.

2. What do you identify as the biggest challenges for women and their families in accessing or receiving maternal health services?
3. Tell me what you consider to be the role of the CHW in providing maternal health services?
4. Do you consider CHWs to be beneficial to improving the availability or utilization of maternal health services? Why or why not?
5. Tell me what you think are the biggest challenges for community health workers in providing care to the community?
6. Do you consider community health workers to be beneficial to improving the availability or utilization of maternal health services? Why or why not?
7. Do you have any experiences with seeing community members being treated unfairly? If so, tell me about this.
8. Do you have any ideas about how Andean culture or beliefs may influence health seeking behaviour? If so, tell me about this.
9. Do you feel that community members are excluded from health services? If so, tell me about this.

Appendix 10: Table of Participants

CN1 - M-F	Community Nurse 1
CN2 - V-F	Community Nurse 2
CW1 - S-F	Community Member 1
CW2 - H-F	Community Member 2
CW3 - E-F	Community Member 3
HCN1 - O-F	Health Center Nurse 1
CHW1 - N-M	Community Health Worker 1
CHW2 - E-F	Community Health Worker 2
CHW3 - W -F (Group Interview)	Community Health Worker 3
CHW4 - L-F (Group Interview)	Community Health Worker 4
CHW5 - M-F (Group Interview)	Community Health Worker 5
CHW6 - P-M	Community Health Worker 6
HUS1 - B-M	Community Member 4
MD1 - Dr. E-M	Medical Doctor 1
MD2 - Dr. R-M	Medical Doctor 2
MD3 - F-M	Medical Doctor 3
MW1 - L-F	Municipal Worker 1
MW2 - L-F	Municipal Worker 2
MW3 - P-F	Municipal Worker 3
NGO1 - E-F	NGO Worker 1
NGO2 - S-F	NGO Worker 2
NGO3 - S-F	NGO Worker 3
NGO4 - S-M	NGO Worker 4
OB1 - A-F	Obstetrician 1
OB2 - C-F	Obstetrician 2
OB3 - S-F	Obstetrician 3

Appendix 11: Sample Participant Observation Checklist

Date: 25/02/12

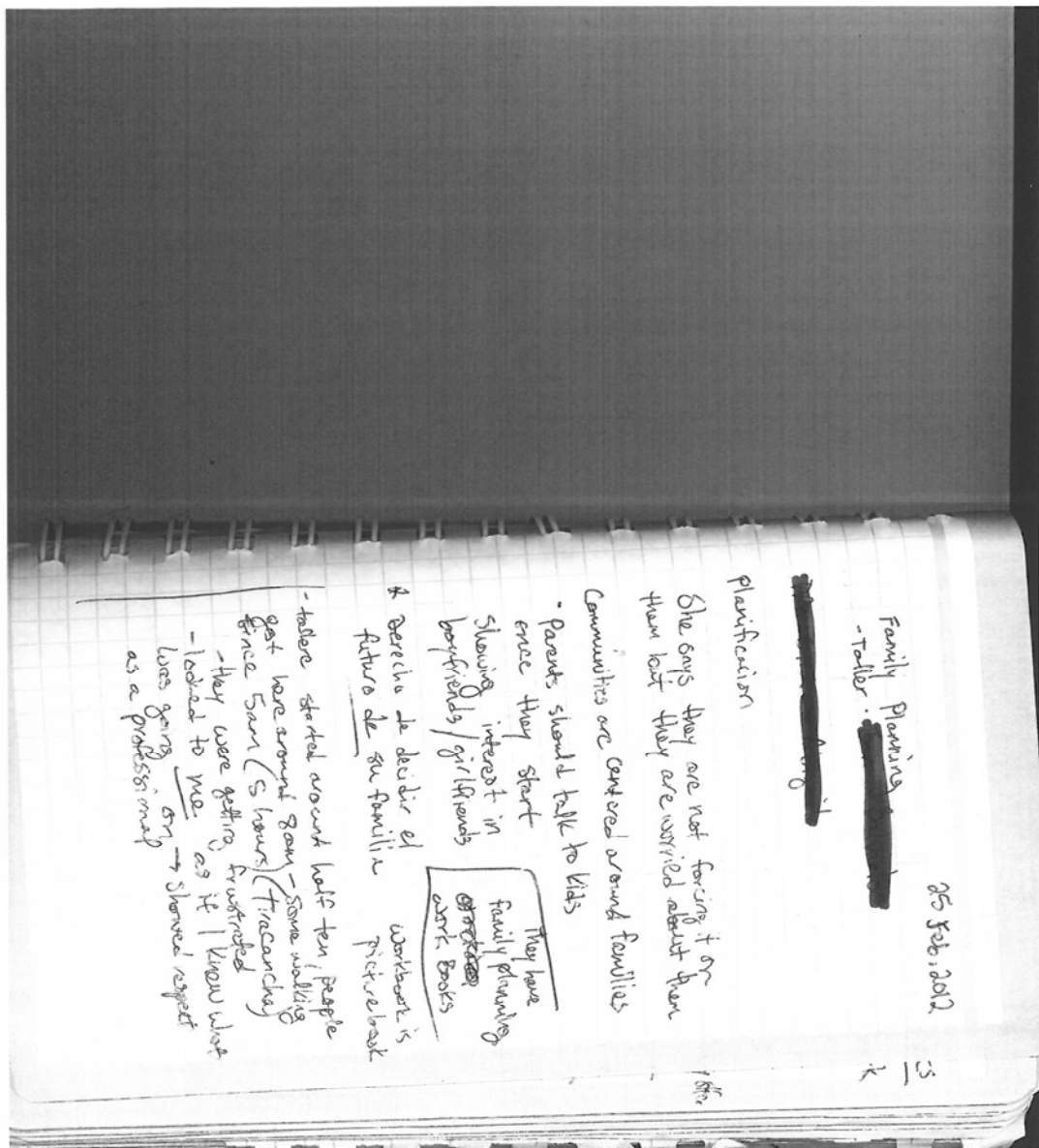
Venue/Location: S.S. Health Center/S.S. (Calca)

Event: Family Planning Workshop for CHWs

Characteristics	Yes	Varies	No	Comments
Quechua used		x		The facilitator would use some Quechua in between Spanish words. Spanish was mostly used. CHWs seemed to understand.
Workshop begins on time			x	Staff arrived over 2 hours late; CHWs were punctual and waiting in lobby during this time.
Full attendance			x	One of the CHWs had to stay back in the community to help her husband work in the fields.
Leaders friendly and responsive to CHWs		x		Sometimes the doctors seemed to talk patronizingly to the CHWs. They did not seem to have much of a reaction to this.

CHWs friendly and responsive to leaders	x			The CHWs listened attentively throughout. Some giggled shyly when personal SRH issues were raised.
CHWs find information clear and easy to understand	x			CHWs seemed to understand information.
CHWs are able to ask questions	x			Some asked questions, but not all.
Lunch or other payment provided	x			A hot lunch of potatoes and rice was provided.

Appendix 12: Participant Observation Notes (pages from field book):



Family Planning counts for planning for the health of the family

"Family Planning is a right"
- This is where cultures clash!
- Men think FP is acting as a contradiction to their rights

methods

Health center is not
"Obligado ni engañado"
pero preocupado!

Don't talk/forget about "methods"
(condoms) but more about ramifications of having kids
+ have many kids

"Planificar"
"nuestra vida"
"la vida de nuestros hijos"

promoters need to send this message at the next community meeting

* why is women/FP so hard? Interviews for Docs

How do they monitor the work of the promoters?

How do they monitor the pregnant & lactating women?

What kinds of incentives do they offer the women to have regular birth

Proxima taller
temas de temas

- no hay partes en caso de en comunidad

necesitan aumentar promotores señeras

- work to grow a
mae consejo program
- promoters should be mothers

At next community meeting, promoters should find madres consejeras to appoint in addition to promoters

~~_____~~
dres no se queren quedar on
mamabost

2011 - 39 mujeres muertas en
Cusco during childbirth

-talking about ramifications
of mothers dying during
birth

4 have births in 2011 in
Sol Solv.

-too much
Health center working to work
with providers to lower
this number.

They don't want to go to
maternity because they have
to care for their husbands,
families, animals etc.

-need to offer incentives!

Family planning to reduce

"Tasa de embarazo"
pregnancy rate

Pobreza = too many kids
"Por que sigo siendo pobre?"

"Cadena de hijos llevando al
callejo etc etc."

hombre
machista

A veces el pueblo no puede luchar
contra el hombre machista

Transcribed field notes:

25th February, 2012

Capacitacion de Promotores - [REDACTED]
Family Planning
[REDACTED]

This training session started at around 10:30. People began arriving at around 8am and some had been walking since 5am in order to arrive on time. There was some confusion again about the location of the session and some CHWs were waiting in a different place. Some were already sitting in the waiting room of the health post when I arrived. The community health workers were unhappy with having to wait so long before beginning. Some had travelled from very far to arrive at the health post and the doctors were not ready on time. They were getting very frustrated. Some kept looking at me as though I was aware of the planning situation and some had assumed that I was a professional (they kept calling me Doctora and treated me with respect).

The delay was mainly due to an obstetric emergency that had occurred that morning and [REDACTED] was busy dealing with this:

The woman that we had seen up in [REDACTED] the month before went into labor while still up in the community. When we saw her the prior month, [REDACTED] told her to make sure to go down to the health center (to the Mamawasi) at least three days before her due date, especially if she started seeing blood. She did not go down. On the day of this training session, the woman went into labor and the ambulance was broken down. [REDACTED] had to walk most of the way to get her. [REDACTED] and some of the community members had to carry her down the very high steep hill and take her to [REDACTED]. The baby was born on the way but they couldn't take the placenta out until they got to the [REDACTED] health center. Both mother and child were okay but this was an example of an obstetric emergency. [REDACTED] was angry because she had told her to make sure to go down to the health center before going into labor and the woman did not do this. Because of this she could have died.

This session was dedicated to family planning. Once it finally got started we all crowded together in one of the very small consulting rooms. This room seemed to be the obstetrician's office. There were about 10 people total made up of both men and women. [REDACTED] started out by saying that family planning is extremely important but it is not something that they are forcing upon them, rather they are giving them this information because they are worried about them.

The communities are centered around families and parents should be talking to their children once they start showing interest in boyfriends or girlfriends.

Each person should have the right to decide the future of their family and nobody can tell them otherwise, not the health centers, not the municipality, and not the husbands.

█████ was showing them the family planning books which were picture books.

█████ was describing that family planning is a right, but that this is where cultures and societal roles find clashes. Men think that family planning is acting as a contradiction to THEIR rights as a man (the right to have his woman whenever he wants).

Family planning methods:

Again she reaffirmed that the health center is not obligating them nor are they trying to trick them, but they are worried about them. This session was not mainly just to talk about the different kinds of birth control methods but more about telling them what the ramifications would be of not planning when and how many kids they are having. They need to plan their lives and plan the lives of their children. Promoters need to relay this message at the next community meeting.

In █████ (town), there are no home births, but this still occurs up in the communities.

█████ begins talking about how there needs to be more female health promoters. She wants to develop a Madres Consejera program, specific for the needs of women of childbirth age. Madres Consejeras are health promoters that are also mothers. She was telling them that at the next community meeting they should find Madres Consejeras to appoint. This would be in addition to the health promoters if possible.

During one of the breaks of this meeting, I asked them if they wanted to participate in my study. Five of them said they would and they were willing to be interviewed after the training session. By the time the meeting was over and lunch had arrived, it was late and they were tired. I was only able to interview three of them as a short group interview. One of the women out of the three sat in on the interview but didn't say much during the recording. She consented to commenting on the interview questions once I turned the recorder off.

Appendix 13: Probing Interview Questions following Theoretical Sampling

1. Links between CHWs and the communities:

Would you say CHWs hold specific status in the communities?

Are CHWs affiliated in any way with the other community leaders?

Would you perceive CHWs as government health workers or community volunteers?

What kinds of opportunities do you think CHWs have for interacting with other CHWs from different communities?

How do you think the community members' ethnicity influences the way they are perceived by others?

Do you think trust plays a role in the way CHWs and community members interact with each other? Is the level of trust influenced by their ethnic similarities or differences?

2. Links between CHWs and health facilities:

To what degree do you think CHWs are linked to health facilities?

Do you know of any difficulties which CHWs may have with staff at health facilities?

How do you perceive being indigenous might influence the way CHWs and health facility staff interact?

How do you think the community members' ethnicity influences the way they are perceived by others?

Do you think trust plays a role in the way CHWs and health facility staff interact with each other? Is the level of trust influenced by their ethnic similarities or differences?

Appendix 14: Example of Analytical Coding Process

Excerpt from interview with a CHW:

“...for the pregnant women, the responsibilities of community health workers are to ask if they are attending their prenatal checkups, if they are going to the health center to have their checkup, to check how they are doing, to see if there are alarm signals or even if they are maybe not feeling well. We have to look in on them every month, also we go to the health center to ask if the pregnant women are attending their checkups or not, and if they are not going, then to go back [to the community] and tell the women that they have to go [to the health center], that it is very important for them, for their babies...we also go to the health centers to learn how to help them. We give talks in the communities, we tell the women that they need to eat well...and for breastfeeding women it is the same as the pregnant women. We ask if they are taking the baby to the health center, we tell them they have to take the baby [to the health center] for checkups. And also that they have to make sure their baby has access to his own food, because he depends on that, just as much as the breast milk. Also, some doctors tell us that that they should be using the colostrum but we know they don't do this and we tell them [the women], that's it's okay to give the babies tea while they discard the spoiled milk,⁸⁰ this is okay as long as they continue to eat healthy so that their unspoiled breast milk is healthy.” (Community Health Worker 2)

⁸⁰ A traditional Quechua belief is that women are more at risk of becoming sick from evil spirits during pregnancy. The colostrum is believed to be spoiled because it was contained in the woman's body throughout pregnancy. The general practice is to discard the colostrum. The infant is generally fed herbal tea while the spoiled milk is being expelled.

Maternal health responsibilities of the CHW		Moving between “communities of place”		Moving between “communities of practice”	
Initial Codes	Focused Codes	Initial Codes	Focused Codes	Initial Codes	Focused Codes
<p>Asking if they are attending their prenatal checkups.</p> <p>Asking if they are going to the health center.</p> <p>Checking how the pregnant women are doing.</p> <p>Seeing if there are alarm signals.</p> <p>Seeing if the pregnant women are not feeling</p>	<p>Feeling responsible for community members health.</p>	<p>Going to the health center to ask if the pregnant women are attending their checkups or not.</p> <p>Going back to the community to tell the women they have to go to the health center.</p> <p>Going to the health center to learn how to help the</p>	<p>Encouraging utilization of health services despite negative expectations.</p> <p>Mediating between community members and health professionals.</p>	<p>Telling the women the baby should have access to other foods in addition to breast milk.</p> <p>Knowing the women prefer not to feed the colostrum to the baby.</p> <p>Telling the women it’s okay to discard the</p>	<p>Condoning traditional practices.</p> <p>Going against higher level medical advice.</p> <p>Valuing traditional and biomedical practices.</p> <p>Choosing which practice to condone.</p>

<p>well.</p> <p>Looking in on the pregnant women once a month.</p> <p>Giving talks in the communities.</p> <p>Telling the women they need to eat well.</p> <p>Asking breastfeeding women if they are taking the baby to the health center.</p> <p>Telling the women they have to take the baby to the health center.</p> <p>Telling the women to</p>		<p>women back in their communities.</p>		<p>colostrum despite knowing the doctors prefer it to be used.</p>	
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make sure the baby has its own food.					
Telling the women it's okay to discard the colostrum despite knowing the doctors prefer it to be used.					

Table 6: Analytical codes derived from the data.

Appendix 15: Sample Memo

Organizing to help their communities overcome health obstacles (29/10/12):

CHWs in the communities are often split into two camps: those that actively try to better their communities, and those that exhibit apathy towards the role. The latter are usually the ones that have been forced to take on the CHW role and don't have time, money or desire to take on this extra responsibility. Going down to the training sessions is an extra burden for all of the CHWs, however for this latter group, it is such a burden that they often do not bother to go at all. The other CHWs that do care and want to be educated and informed enough to help their communities, also often cannot attend the training sessions due to a variety of time and financial constraints; however they try to go as much as they can.

Most of the CHWs I met with were very positive about the work that they do. They know that there are problems in their communities. Poor living standards are causing illnesses in their communities and they are aware of this. They actively work to try to better these living standards. They want to help their communities overcome the obstacles that lead to poor health. These are the ones that actively participate in the training sessions and visit their fellow campesinos to impart the information that they have gathered and been taught. Many have stated that they feel pride in the work that they do. They enjoy helping others and they enjoy having people look up to them and ask them for advice. They are treated as community authorities and take pride in this. They enjoy when development organizers and health professionals treat them as community representatives.

One of the main problems they cite however is that they feel they are not being listened to or given enough attention by people outside the community (development organizers and health professionals). Many were particularly referring to the municipality and in the case of one of the districts covered in this study, there was one very specific municipal worker that was held in extreme disdain. This person was constantly yelling at them and talking down to them. The lack of communication however extends beyond the poor treatment from the municipality. They also cite not always being taken seriously by health professionals. They expressed that even though some of the health professionals did show interest in their experiences in providing care to the communities, they would have liked for the health professionals to share more of their own experiences with them (the CHWs). They felt mostly that the health professionals were just there to tell them what to do. The information that the health professionals gave them during the training sessions seemed to be imposed on them and many said that they wanted to learn very specific things given the specific needs of the communities and that the organizers of the trainings did not teach them what they were asking to be taught. Basic first aid is taught to them, and they were very happy about this, however because they are given "information" rather than actual medical intervention training, they sometimes feel helpless if an emergency were to happen in the community. This sometimes also leads to

community members getting upset with them when they are not equipped with actual medicines or the ability to medically treat ailments or deal with obstetric emergencies.

The organizers have a list of topics that need to be covered during the training sessions and they organize these into monthly sessions (meetings do not always take place however which means that often many months can go by without a session). Because of this, the schedule may be backed up and what they were expecting to be taught can get pushed back or forgotten completely. Because of this, the CHWs stressed that the people in charge of planning and organizing community development programs (including CHW training sessions), did not fully understand the needs of the communities. There seems to be an extreme lack of communication between organizers, CHWs and of course the community members. A recommendation to follow up on would be to perhaps have the organizers be more open with the CHWs about what they are going to learn, when they are going to learn it, and why they aren't being taught what they had asked for. When this was suggested by some of the participants (during informal conversation), many responded by saying that they often felt municipal and health workers kept information from them because they didn't think they were valued enough by the organizers to be told.

Community members have thus exhibited a keen desire to organize themselves in order to actively improve living conditions in their communities, which they see as directly related to the health status of their fellow campesinos. They cite an immense feeling of pride in being able to provide information and help in as many ways as they can. However a main concern is that they feel undervalued by organizers and this results in less motivation to take part in activities. They often say they feel more valued as health authorities by their own community members rather than the health professionals or development organizers, but also having this authority within the community can lead to other problems with the other campesinos, such as being held responsible for complications that they are not able (or legally allowed) to treat.

They seem to be stuck in a middle ground: they want more responsibility and information so as to maintain this authority, however they recognize that increased authority will lead to further expectations of the functions they serve in the community. To deal with this, they continue requesting support from the organizers, often expressing unhappiness at being yelled at and not being listened to, but they also supplement their lack of biomedical treatment abilities with home remedies and traditional healing methods. In this regard, this group of CHWs (excluding the ones that have been "forced" into the role and show apathy) display an example of active organization to meet the needs of their own community members. This actually contrasts the common opinion about Cusqueñan community members allowing themselves to remain voiceless because of their shared history of domination and subjugation (during the Inca times as well as Spanish colonization). (See below excerpt from Identity in the Andes)

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Identity in the Andes:

According to Muñoz (2007: 1933) (See Group Inequalities and Nature of Collective Action), Andean identity is primarily referenced by the community to they belong to. In other words the allegiance is to the particular community rather than an entire "Andean nation".

Throughout my fieldwork, I personally have observed this to be true, however in the case of Cusco, there is a stronger emphasis on feeling pride towards belonging to the lands once inhabited by the Incas. This is a shared historical reference and seems to play a great role in how Andeans from this particular region of Peru identify themselves. This is due to the shared cultural and historical experience unique to Cusqueños. Peru, after all is known worldwide by the importance of the Inca Empire, and Cusqueños are aware of this international and national notoriety, constantly referring to themselves as "Inca Wasi" (children of the Incas).

There is a common observance among development organizers regarding Cusqueños specifically and this also has to do with the shared historical experience. Cusqueños went through years of domination by multiple actors including the Inca elites, Spanish settlers, and rich landowners of both Spanish and Andean origin. Because of this history of domination, Cusqueños became used to having others impose rules on them, changing their lifestyles and habits. They were suppressed and now according to many development organizers, because of this, they allow themselves to remain voiceless and do not assert their rights, often not even knowing that they have rights or what they are if they do have them. This hinders them from actively organizing to improve their own livelihoods. Instead they wait to be organized and do not take an active role in developing their communities. Some organizers even comment that they become angry when community members complain that they do not receive the right information however they do not do anything about it.

Appendix 16: Analysis Table

Theoretical categories	Focused codes leading to theoretical categories
1. Feeling Internal Conflict	<ul style="list-style-type: none"> -Witnessing discrimination towards others -Feeling suppressed because of ethnicity. -Feeling forgotten as an ethnic group Feeling a need to change people's mentality -Feeling pride in being Peruvian -Accepting poor treatment from health professionals
2. Being Influenced by Assumptions	<ul style="list-style-type: none"> -Avoiding interaction because of poor treatment expectations -Assuming all community members are uneducated -Feeling scared to say negative things about health professionals -Feeling stigma for having too many children
3. Adopting Professional	<ul style="list-style-type: none"> -Feeling like a community authority figure -Having studied enough to acknowledge if mistakes are made

Identity	<ul style="list-style-type: none"> -Being identified as a CHW -Feeling responsible for community members health -Acting as community spokesperson -Community members being thankful for CHWs work
4. Bargaining Ethnic Identity	<ul style="list-style-type: none"> -Weighing the value of different identities -Categorizing ethnicity for pragmatic purposes -Identifying fluidity of identities
5. Being Empowered	<ul style="list-style-type: none"> -Acting as a community spokesperson -Liaising with health professionals and municipal workers -Feeling confidence in basic health care provision abilities
6. Negotiating Trust	<ul style="list-style-type: none"> -Acting as a community spokesperson -Feeling CHWs know too much -Feeling greater trust toward in-group members
7. Facilitating Interactions	<ul style="list-style-type: none"> -Encouraging utilization of health services despite negative expectations -Mediating between community members and health

	<p>professionals</p> <ul style="list-style-type: none"> -Pragmatically utilizing bargained ethnic and professional identity to reinforce trust relations between groups -Fostering links between groups
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Appendix 17: Fieldwork Photos

